




PPRC

---

*Annual Report to Congress*

---

1997



Physician  
Payment  
Review  
Commission





R  
728.5  
.U527  
1997

PPRC

*Annual Report to Congress*

1997

Physician  
Payment  
Review  
Commission

2120 L Street, NW, Suite 200, Washington, DC 20037

(202) 653-7220 fax (202) 653-7238

[www.pprc.gov](http://www.pprc.gov)



CMS Library  
02 07 13  
7500 Security Blvd.  
Baltimore, MD 21204







---

# Acknowledgements

The Physician Payment Review Commission's 1997 annual report to the Congress could not have been prepared without the generous assistance of many people. As in previous years, this year's report presents work conducted by the Commission and its staff as well as by outside experts. It reflects the Commission's ongoing relationship with physicians and other health professionals, consumers, payers, and others affected by its work. The Commissioners and staff would like to thank all those who have contributed to its work in the past year. Staff of the Congress, the Health Care Financing Administration (particularly the Bureau of Data Management and Strategy) and other agencies of the Department of Health and Human Services, the Congressional Budget Office, the Congressional Research Service, the General Accounting Office, and the Prospective Payment Assessment Commission provided invaluable information and advice.

As in years past, the Commission has been fortunate to work with a group of people who have consistently understood and responded to its needs in key areas. Social and Scientific Systems—especially Arlene Turner, Jeff McCartney, and Rosanne Russillo—upheld their excellent record of meeting the challenges posed by the Commission's diverse programming needs. In the process of editing this report, Lynn Lewis again helped the staff to convey complex and technical material in an effective manner. Karin Shipman shared her creativity through the design of this report and other publications that highlight the Commission's work throughout the year.

The Commission also benefited from the contributions of staff members who have left during the course of the year. Donna Farley and Lori Gruber helped to lay the framework for the Commission's analyses related to Medicare risk-plan payment



policies, beneficiaries' financial liability, and measuring the effects of secondary insurance on Medicare expenditures.

The Commission benefited greatly in its work on beneficiary access in Medicare risk plans from collaboration with a group of experts in survey research. Marsha Gold, Lyle Nelson, Randy Brown, and Anne Ciemnecki of Mathematica Policy Research played key roles in conducting and reporting on the results of the Commission's survey of risk-plan enrollees and disenrollees.

As part of its ongoing study of the changing health care market, the Commission convened an expert panel to discuss issues surrounding the growth and development of provider-sponsored organizations (PSOs). Staff of Mathematica Policy Research played a key role in identifying and convening these panelists. Panel participants provided the Commission with invaluable perspectives on the characteristics, structure, operations, and financial aspects of PSOs, as well as on some of the regulatory, licensure, and purchasing issues that surround these plans. For sharing their insights, special thanks go to Tony Barrueta, Patricia Drury, Allen Feezor, Peter Fox, James Fritz, Russ Gardner, John Gray, Scott Harrison, Donald Hutton, Carol Jimenez, William Kopit, Dixon Larkin, Rosalio Lopez, David Manning, Kip May, and Sandra Reifsteck.

The Commission's work on monitoring beneficiary access continued to be guided and informed by its Advisory Panel on Access. Thanks go to Perham Amsden, Geraldine Dallek, Lynn Etheredge, Harold Freeman, Lucian Leape, Stephen Long, Nicole Lurie, Ira Moscovice, Martin Shapiro, Richard Tompkins, and Barbara Yawn for their participation on that ongoing panel.

Throughout the year, the Commission seeks comments on its work from many organizations concerned about the issues on its agenda. The information it receives through formal testimony, comments on draft chapters, and interactions with these groups always enhances its work. It appreciates the efforts made by these organizations.

A number of other people played a key role in Commission activities during the past year. For their efforts, special thanks go to Marty Abeln, Rachel Block, David Blumenthal, Lorraine Brown, Bill Clark, Bryan Dowd, Frank Eppig, Linda Fishman, Andreas Frank, Beth Fuchs, David Gibson, Ron Gresch, Ian Hill, Jane Horvath, Bob Hurley, Edwin Hustead, Mel Ingber, Tracy Johnson, Jeffrey Kang, Terry Kay, Mark Kelley, Nancy Kichak, Kathy King, Bob Leibenluft, Jeff Lemieux, Tom Lindquist, Joe Martingale, Cynthia Mason, Renee Mentnech, Robert Mollica, Larry Patton, James Reuter, Gerald Riley, Alina Salganicoff, Paul Saucier, Patricia Seliger, Sandy Sherman, Mary Stojak, Don Thompson, Cynthia Tudor, and Robin Wythe.



---

# Commission Members

*Gail R. Wilensky, Ph.D., Chair*

Project HOPE

Bethesda, MD

*Linda H. Aiken, Ph.D.*

University of Pennsylvania

Philadelphia, PA

*Richard V. Anderson*

Kaiser Permanente Foundation Health Plan

Oakland, CA

*Giles G. Bole, M.D.*

University of Michigan

Ann Arbor, MI

*P. William Curreri, M.D.*

Strategem of Alabama, Inc.

Mobile, AL

*Anne B. Jackson*

Sarasota, FL

*Donald Theodore Lewers, M.D.*

Private Practice of Medicine

Easton, MD

*Mark V. Pauly, Ph.D.*

University of Pennsylvania

Philadelphia, PA

*Patricia E. Powers*

Pacific Business Group on Health

San Francisco, CA

*Frank A. Sloan, Ph.D.*

Duke University

Durham, NC

*Earl P. Steinberg, M.D.*

Covance Inc.

Washington, DC

*Ray E. Stowers, D.O.*

Medford Family Clinic

Medford, OK

*Roger S. Taylor, M.D., M.P.A.*

Connecticut Health Enterprises

Monroe, CT





---

# Commission Staff

Lauren B. LeRoy, Ph.D.  
*Executive Director*

David C. Colby, Ph.D.  
*Deputy Director*

Anne L. Schwartz, Ph.D.  
*Special Assistant to the Executive Director*

## *Principal Policy Analysts*

John F. Hoadley, Ph.D.  
Christopher Hogan, Ph.D.

## *Senior Analysts*

Donald F. Cox, Ph.D.  
Elizabeth Docteur, M.S.  
Kevin Hayes, Ph.D.  
Katie Merrell  
Michael J. O'Grady, Ph.D.  
David W. Shapiro, M.D., J.D.  
Sally Trude, Ph.D.

## *Analysts*

Christine M. Cushman, M.P.P.  
Sarah Hespenheide Wiley, M.H.S.

## *Administrative Staff*

Diane Ellison  
Annette Hennessey  
Ann Johnson  
Deborah Kramer  
Joyce Malones  
Cynthia Wilson





---

# Contents

Acknowledgements .....	iii
Members and Staff .....	v
Summary and Recommendations .....	xix

## Chapters

1	The Context for Medicare and Medicaid Policy .....	1
2	Medicare Managed Care: Participation and Payment .....	21
3	Revising the Method for Determining Medicare Capitated Payments .....	53
4	Implementing Risk Adjustment in the Medicare Program ...	77
5	Promoting Access to Care for Vulnerable Populations in Medicare Managed Care .....	103
6	Access to Care in Medicare Risk Plans .....	129
7	Using Quality and Performance Measures in Medicare .....	147
8	Issues Concerning Data Reporting by Health Plans .....	161
9	Competitive Premium Contribution Models: Issues for Medicare .....	177
10	Provider-Sponsored Organizations .....	201
11	Consumer Protection Initiatives for Managed Care .....	233
12	Constraining Spending in Medicare Fee for Service .....	247
13	Medicare Fee Schedule Payment Issues .....	261
14	Access and Beneficiary Financial Liability under the Medicare Fee Schedule .....	299
15	Private Secondary Insurance for Medicare Beneficiaries .....	317
16	The Changing Labor Market for Physicians .....	345
17	Academic Medical Centers and the Changing Health Care Marketplace .....	357
18	Financing Graduate Medical Education and Teaching Hospitals from a Trust Fund .....	381
19	Managing Health Care for Dually Eligible Beneficiaries .....	397
20	Medicaid: Spending Trends and the Move to Managed Care ..	413

---

## Appendices

A	Update on Provider-Sponsored Organizations and the Antitrust Laws .....	449
B	Commission and Staff Biographies .....	457
C	Commission Responsibilities Mandated by Congress .....	467
D	Commission Publications .....	469
E	Glossary .....	477

## Figures

1-1	The Composition of the Medicare Population by Age, 1995 ..	3
1-2	Distribution of Medicare Spending for Elderly Beneficiaries, 1993 .....	4
1-3	Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1993 .....	4
1-4	Out-of-Pocket Health Spending for the Noninstitutionalized Elderly as a Percent of Family Income, 1996 .....	5
1-5	Supplemental Insurance Status of Beneficiaries in Medicare Fee for Service, 1995 .....	6
1-6	Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995 .....	8
1-7	The Nation's Health Dollar, 1995 .....	9
1-8	Medicare Enrollment and Expenditures, 1975-1995 .....	9
1-9	Projected Medicare Hospital Insurance Trust Fund Balance, 1996-2005 .....	10
1-10	Actual and Projected Growth in Gross Domestic Product (GDP) and Total Medicare Spending, 1990-2002 .....	11
1-11	Total Medicare Expenditures, 1970-1995 .....	12
1-12	Growth in Expenditures per Enrollee for Medicare and Private Health Insurance, 1970-1995 .....	14
1-13	Insured Workers Covered by Different Types of Plans, 1993 and 1995 .....	17
1-14	Trends in Managed-Care Enrollment, 1991-1996 .....	18
2-1	Risk Plans Participating in Medicare, 1987-1996 .....	25
2-2	Distribution of Medicare Beneficiaries, by Number of Risk Plans Available in Their Area, 1995-1996 .....	26
2-3	Percent of State Medicare Population with at Least One Risk Plan Available, June 1996 .....	27



---

2-4	Distribution of Medicare Beneficiaries in Urban and Rural Locations, by Number of Available Plans, June 1996 . . . . .	29
2-5	Medicare Risk-Plan and Cost-Plan Enrollment, 1990-1996 . . .	33
2-6	Medicare Risk-Plan and Cost-Plan Enrollment, by Urban and Rural Locations, June 1996 . . . . .	34
2-7	Medicare Risk-Plan Enrollment, by State, December 1996 . . .	35
2-8	Distribution of Medicare Beneficiaries and Risk Enrollees, by State, December 1996 . . . . .	37
2-9	Distribution of Medicare Risk Enrollees and New Enrollees, by State, December 1996 . . . . .	38
2-10	Medicare Risk-Plan Enrollment in 31 Large Primary Metropolitan Statistical Areas, June 1996 . . . . .	39
2-11	Medicare Risk-Plan Enrollment, by Number of Plans Available in Area, June 1996 . . . . .	40
2-12	Spread of County Payment Rates, by Urban and Rural Location, 1997 . . . . .	44
2-13	Spread of County Payment Rates within Selected Primary Metropolitan Statistical Areas, 1997 . . . . .	45
2-14	Additional Benefits Medicare Risk Plans Offer in Their Basic Option Package, December 1996 . . . . .	48
2-15	Distribution of Medicare Risk Plans by Monthly Premium Charged, 1995-1996 . . . . .	48
3-1	Comparison of Alternative Measures of HMO Penetration, 1994 . . . . .	72
4-1	Costs as a Percentage of Average Medicare Spending per Beneficiary . . . . .	80
6-1	Most Important Reasons for Enrolling in Medicare Risk Plans . . . . .	133
6-2	Most Important Reasons for Switching or Disenrolling from Medicare Risk Plans . . . . .	134
6-3	Problems Obtaining Access to Services Among Medicare Risk Plan Enrollees . . . . .	136
6-4	Selected Measures of Satisfaction for Medicare Risk Plan Enrollees . . . . .	138
6-5	Use of Preventive Care in Medicare in Past Year . . . . .	141
9-1	Annual Premium and Federal Contribution for Self-Only Coverage, Federal Employees Health Benefits Program, 1996 . . . . .	182
9-2	Annual Premium and State Contribution for Self-Only Coverage, California Public Employees' Retirement System, 1996 . . . . .	185

---

---

10-1	Classifying Provider-Sponsored Organizations by Extent of Integration .....	204
10-2	Comparison of per Enrollee Financial Assets for Provider and Non-Provider-Owned Licensed HMOs, 1993 .....	209
10-3	State Approaches to Regulating Provider-Sponsored Organizations .....	212
12-1	Projections of Spending by Health Care Sector, 1996-2003 ..	249
12-2	Projected Spending Targets for Physicians' Services Compared to Growth in Nominal GDP and Total Medicare Spending, 1990-2002 .....	252
12-3	Shares of Total Medicare Outlays, by Sector, 1986-1996 ....	257
12-4	Annual Spending Growth for Various Sectors, 1987-1995 ....	258
13-1	Comparison of Three Estimates of Resource-Based Practice Expense Relative Values, for Selected Specialties .....	273
13-2	Counties of the Chicago Metropolitan Statistical Area, by Fee Schedule Payment Area .....	289
13-3	Counties of the East St. Louis Fee Schedule Payment Area, by Metropolitan Statistical Area Status .....	290
13-4	Counties of the St. Louis Metropolitan Statistical Area (Missouri Part), by Fee Schedule Payment Area .....	291
14-1	Beneficiaries Who Are Very Satisfied with Overall Quality of Care, by Health Status .....	307
14-2	Beneficiaries with No Usual Source of Care, by Health Status .....	309
14-3	Beneficiaries with No Usual Source of Care, by Supplemental Coverage .....	309
14-4	Beneficiaries with No Usual Source of Care, by Race .....	310
14-5	Beneficiaries Very Satisfied with Overall Quality of Care, by Race .....	310
14-6	Average Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income by Poverty Status, 1996 .....	313
15-1	Supplemental Insurance Status of Beneficiaries in Medicare Fee for Service, 1995 .....	319
15-2	Large Firms' Premium Contributions for Medicare-Eligible Retirees' Health Coverage, by Type of Coverage, 1995 ....	322
15-3	Percentage of Large Firms Offering Retiree Health Coverage to Medicare-Eligible Retirees, 1993-1996 .....	323
15-4	Comparison of Projected per Capita Spending for Average Beneficiaries, by Type of Supplemental Insurance and Year	328

---



---

16-1	Applicants and First-Year Enrollment in U.S. Medical Schools, 1975-1995 .....	354
17-1	Composition of Revenues of U.S. Allopathic Medical Schools, 1994-1995 .....	359
17-2	Share of U.S. Allopathic Medical School Revenues from Faculty Practice Plans, 1960-1995 .....	359
17-3	Academic Health Centers' Perceptions about Changes in their Financial Positions, 1993-1994 .....	366
17-4	Composition of Faculty Practice Plan Professional Services Revenues by Payer, 1995 .....	368
17-5	How Academic Medical Centers Build Primary Care Capacity .....	373
19-1	Medicaid Payments for the Aged, by Type of Service, 1994 ..	403
20-1	Medicaid Beneficiaries and Expenditures, by Enrollment Group, 1995 .....	418
20-2	Medicaid Expenditures per Beneficiary, 1995 .....	419
20-3	Medicaid Expenditures by Type of Service, 1995 .....	420
20-4	Average Annual Medicaid Expenditure Growth Rate, 1988-2002 .....	422
20-5	Status of Section 1115 State Medicaid Waivers, December 1996 .....	426
20-6	Enrollment Growth in All Types of Medicaid Managed Care, 1991-1996 .....	431
20-7	Enrollment in Any Type of Medicaid Managed Care, 1996 ..	431
20-8	Distribution of Medicaid Managed-Care Enrollment, by Type of Arrangement, 1996 .....	433
20-9	Enrollment in Risk-Based Managed Care, 1996 .....	435

## Tables

1-1	Medicare Expenditures and Average Annual Rates of Growth, by Service Category, Selected Calendar Years, 1985-1995 .....	12
2-1	Availability of Medicare Risk Plans and Enrollment, by State, June 1996 .....	28
2-2	Availability of Medicare Risk Plans and Enrollment, by Primary Metropolitan Statistical Area, June 1996 .....	30
2-3	Overlap between Plan Service Areas and Counties in the Boston Primary Metropolitan Statistical Area, June 1996 ..	31

---

---

2-4	Overlap between Plan Service Areas and Counties in the Chicago Primary Metropolitan Statistical Area, June 1996 . .	32
2-5	Enrollment in Medicare Risk Plans, 1995 and 1996 . . . . .	36
2-6	Projected Monthly U.S. per Capita Costs, by Medicare Part and Beneficiary Eligibility Status, 1997 . . . . .	41
2-7	Medicare Demographic Risk Adjusters for Aged Beneficiaries, 1997 . . . . .	42
2-8	Calculation of Risk-Plan Monthly Payment on Behalf of Selected Beneficiaries, Los Angeles County, California, 1997 . . . . .	43
2-9	Calculation of Adjusted Community Rate, Using National Average Amounts, 1995 . . . . .	46
2-10	Risk-Plan Benefits and Premiums Based on Adjusted Community Rate Proposals, by Market, 1995 . . . . .	49
2-11	Risk-Plan Benefits and Premiums, by Market, June 1996 . . .	50
3-1	Derivation of Medicare Risk-Plan Payment Rates from Fee- for-Service Outlays, Selected Counties, 1995 . . . . .	57
3-2	Example of the Calculation of 1995 Payments to Four Hypothetical Risk Plans in Cook County, Illinois . . . . .	58
3-3	Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk-Plan Payment Rates, by Urban and Rural Location, 1995 . . . . .	62
3-4	Effect of Diagnosis-Based Risk Adjustment on 1995 Medicare Risk-Plan Payment Base Rates, Selected Counties . . . . .	63
3-5	Comparison of Medicare Per Capita Cost (MPCC) Rates with Current Risk-Plan Payment Rates, 1996 and 1997 . .	67
3-6	County Population, Payment Volatility, and Risk Enrollment Rate . . . . .	70
4-1	Concentration of HMO Enrollment in Medicare, 1996 . . . . .	91
4-2	Medicare Managed-Care Enrollees That Have Been Enrolled for Three Years or Less . . . . .	94
4-3	Length of HMO Enrollment for Medicare Enrollees in Five Large Risk Contracts, June 1994 . . . . .	94
4-4	Effect of Risk Adjustment on County Base Payment Rates, Top 50 Metropolitan Statistical Areas or State Rural Areas . . . . .	98
5-1	Distribution of Annual Charges for Potentially Vulnerable Medicare Beneficiaries . . . . .	108

---



---

5-2	Average Profit or Loss per Beneficiary Estimated from 1995 Medicare Current Beneficiary Survey Fee-for-Service Payments and 1994 Capitation Payments.....	114
5-3	Beneficiaries in Vulnerable Groups by Enrollment in Managed Care or Fee for Service .....	115
5-4	Effect of Clinical Diagnoses and Health Status and Functioning Risk Adjustment on Estimated Average Profit and Loss by Vulnerable Group .....	116
5-5	Effect of Various Outlier Payment Policies and Health Status Risk Adjustments on Differences in Estimated Average Profit and Loss by Vulnerable Group .....	118
6-1	Selected Access Measures for Medicare Risk-Plan Enrollees, by Vulnerable Subgroup .....	140
6-2	Access Problems Experienced by All Beneficiaries and by Vulnerable Subgroups in Medicare Risk Plans and Fee-for-Service Medicare .....	142
6-3	Access Problems Experienced by Vulnerable Subgroups Relative to Their Counterparts, in Medicare Risk Plans and Fee for Service .....	143
9-1	Comparison of Beneficiary Premiums and Federal Contributions with Different Levels of Beneficiary Savings .....	194
10-1	Comparison of Selected Characteristics for Provider and Non-Provider-Owned Licensed HMOs, 1993 .....	208
12-1	Performance Standards, by Category of Service, 1990-1997 ..	250
12-2	Components of Expenditure Growth, for 1997 Performance Standards, by Category of Service .....	251
12-3	Calculation of the 1997 Performance Standards, by Category of Service .....	251
12-4	Conversion Factor Updates, by Category of Service, 1992-1997.....	253
12-5	Conversion Factors, by Category of Service, 1992-1997.....	253
12-6	Estimated Annual per Capita Spending in Medicare Fee for Service and Managed Care by Geographic Area .....	259
13-1	Effect of Policy Changes on Fee Schedule Payments, 1995-1996.....	263
13-2	Distribution of Changes in Relative Value Units under Resource-Based Practice Expense Estimates .....	266

---

---

13-3	Ratio of Estimates of Resource-Based Practice Expense to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty . . .	267
13-4	Summary of Four Research Studies Relating to Practice Expense . . . . .	269
13-5	Ratio of Harvard Study Estimates to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty . . . . .	271
13-6	Ratio of Health Economics Research Study Estimates to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty . . .	272
13-7	Correlation Coefficients among Physician Payment Review Commission, Harvard Site-of-Service, and Health Economics Research Site-of-Service Direct Cost Relative Values . . . . .	274
13-8	Effect of the Five-Year Review on Medicare Fee Schedule Payments, by Specialty . . . . .	280
13-9	Effect of Payment Area Revision on Number of Payment Areas by State . . . . .	287
13-10	Border-Crossing Metropolitan Statistical Area and Their Geographic Adjustment Factors . . . . .	293
14-1	Change in Payment and Use per Beneficiary for Selected Services, 1992-1996 . . . . .	302
14-2	Medicare Beneficiaries Reporting Problems with Access, 1995 . . . . .	305
14-3	Medicare Beneficiaries' Attitudes Toward the Care They Receive, 1995 . . . . .	306
15-1	Benefits Covered under Standard Medigap Policies and Sales Distribution of Different Plans . . . . .	320
15-2	Estimated Medicare SELECT Cost Impacts . . . . .	337
16-1	Real Median Physician Income, by Selected Specialties and Years . . . . .	348
16-2	Graduating Allopathic Medical Students' Career Preferences, by Selected Specialties and Years, 1980-1996 . . . . .	349
16-3	Distribution of First-Year Residents, by Selected Specialties and Years, 1980-1995 . . . . .	350
16-4	First-Year Residents, by Selected Specialties and Years, 1980-1995 . . . . .	351

---



---

16-5	Trends in the Number and Percentage of Residents Who Are International Medical Graduates, by Selected Years, 1970-1995 .....	352
16-6	Shares of Total Residents Who Are International Medical Graduates, by Selected Specialties and Years, 1990-1995 .....	352
16-7	Total Residents, by Selected Specialties and Years, 1980-1995 .....	353
16-8	Number of Allopathic Residency Programs, by Selected Specialties and Years, 1979-1995 .....	353
17-1	Total and Medicare Inpatient Margins by Hospital Type, Fiscal Year 1995 .....	367
19-1	Coverage of Medicare Premiums, Cost Sharing, and Additional Benefits by State Medicaid Programs .....	400
19-2	Characteristics of Dually Eligible Beneficiaries and Other Medicare Beneficiaries, 1995 .....	401
19-3	Enrollment of Medicaid Beneficiaries and Medicaid Expenditures for Services, by Eligibility Group, 1994 .....	402
20-1	Medicaid Expenditures by State, 1994 .....	421
20-2	Enrollment in Medicaid Managed Care, by Range of Services Covered, 1995 .....	429
20-3	Enrollment in Medicaid Managed Care, with Adjustments for Dental and Behavioral Health Plans, 1995 .....	430
20-4	Enrollment in Any Medicaid Managed-Care Plans, 1994-1996 .....	432
20-5	Enrollment in Medicaid Risk-Based Managed-Care Plans, 1994-1996 .....	436
20-6	Medicaid Spending on Managed Care, for States with over 25 Percent Enrollment, 1994 .....	437

---





---

# Summary and Recommendations

Over the past decade, the American health system has changed dramatically. In the mid-1980s, most Americans with health insurance, whether public or private, had indemnity coverage, as they had 20 years earlier when Medicare was enacted. Congressional action affecting the Medicare program, including major reforms in hospital and physician payment, assumed that fee-for-service medicine would remain the principal form of health care financing and delivery.

Today's market is markedly different. The number of people with traditional indemnity insurance has been shrinking. Managed-care plans are evolving into integrated systems with closer links to their provider networks, while physicians and hospitals are joining together in new types of organizations. Responding to climbing premiums, leading corporate purchasers of health care are changing how they pay for health services, with potential consequences for costs and quality.

These trends present Medicare, Medicaid, and the broader health system with new challenges. Over the past year, the Physician Payment Review Commission has analyzed critical issues concerning the future of these programs—issues that affect Medicare managed care and fee for service, issues relevant to Medicaid managed care, and issues affecting other aspects of the health system.

## Medicare Managed Care: Participation and Payment

Although managed-care options have been available to some Medicare beneficiaries for over 20 years, enrollment has only recently begun to accelerate. Nearly 13 percent of beneficiaries are now enrolled in managed-care plans. Health maintenance organizations (HMOs) (some of which offer point-of-service coverage) are the only plan option. The Health Care Financing Administration's (HCFA's) Medicare Choices demonstration is testing different types of managed-care products, however.

Most Medicare managed-care plans have risk contracts requiring them to provide all Medicare-covered services for a set monthly payment. That payment is based on 95 percent of average per capita fee-for-service outlays in each county, adjusted for the demographic characteristics of a plan's enrollees. If plans' estimated Medicare costs (including normal markup) are below their Medicare revenues, they must either return the difference to Medicare or provide additional benefits to enrollees at no additional cost. As a result of this requirement and local competitive pressures, plans offer a variety of benefits to beneficiaries beyond those covered by Medicare. The premiums charged for these additional benefits vary across plans and markets. By late 1996, two-thirds of plans charged no premium for their basic package.

Between 1993 and 1996, the number of risk plans more than doubled. By mid-1996, about 63 percent of beneficiaries lived in areas served by at least one risk plan. Availability is clustered primarily in urban areas; there are no plans for over 80 percent of rural beneficiaries. Plan availability also varies widely within states.

The percentage of Medicare beneficiaries enrolled in risk plans more than doubled between 1993 and 1996, growing 34 percent in 1996. The geographic distribution of enrollees mirrors that of plans, with enrollment in urban cores exceeding 20 percent and rates in rural areas at 1 percent. More than one-quarter of beneficiaries in three states—Arizona, California, and Oregon—are in risk plans, whereas enrollment is less than 2 percent in 23 states. Five states have two-thirds of total risk-plan enrollment, though they account for only one-third of all beneficiaries.

There is a threefold difference in payment rates nationwide. Rates are higher in urban areas than in rural ones where annual per capita spending is volatile. Since payment rates are set by county, they can vary widely within metropolitan areas.



# Revising the Method for Determining Medicare Capitated Payments

Recent growth in Medicare's risk program, coupled with interest in broadening beneficiary choices and curbing growth in Medicare outlays, has focused attention on improving methods for determining payments to risk plans. Many observers think current policies limit the growth of Medicare managed care by paying too little in some markets and promoting it in others by paying more than necessary to compensate plans fairly. In any case, these policies hamper Medicare's ability to benefit from the efficiencies of managed care. Moreover, they do not encourage beneficiaries to make cost-conscious choices.

Risk-plan payments are based on the adjusted average per capita cost (AAPCC) for fee-for-service beneficiaries at the county level. These rates vary widely across the nation and change erratically each year in some areas, particularly in less-populous counties. Payment rate differences are not fully explained by variations in either the underlying health status of the Medicare population or the local prices of the inputs used to produce health care, such as nursing wages or office rents. These differences also reflect the effect of different practice styles and patient preferences on health care costs. The AAPCC's variation and volatility may contribute to an uneven pattern of Medicare managed-care enrollment, as well as the wide variation in additional benefits and premiums beneficiaries face.

Several technical factors contribute to geographic variation in the AAPCC. The most important include:

- Inadequacies of current demographic risk adjusters, which reflect beneficiaries who remain in fee-for-service. To the extent that they are less healthy and that this fact is not captured by current risk adjusters, expected fee-for-service payments overstate expected costs for managed-care enrollees.
- Inclusion of earmarked funds to hospitals for graduate medical education (GME) and for serving a disproportionate share of low-income patients.

Inclusion of these payments raises questions about whether they should be passed along to all risk plans.

- Basing rates on counties. Using geographic areas larger than counties would reduce the variation and volatility in local base rates. Larger areas may also be more consistent with managed-care market areas. Small areas, however, help offset some of the weaknesses of current risk adjustment, since there is across-county variation in risk status. Implementation of larger areas, therefore, should be accompanied by implementation of better risk adjusters.

*Several modifications should be adopted to make the adjusted average per capita cost (AAPCC) a more reliable estimate of expected patient care costs. Among these are using better risk-adjustment methods; excluding payments to hospitals for graduate medical education expenses and serving a disproportionate share of low-income patients; including the cost of care currently provided by other institutions like the Departments of Veterans Affairs and Defense, which is likely to be furnished by managed-care plans; and basing the AAPCC on larger geographic areas.*

*Once graduate medical education costs are removed from the AAPCC, new mechanisms should be developed to ensure that hospitals, managed-care organizations, and other training entities are paid fairly for these costs when they are involved in appropriate training activities. Medicare payment policies should be developed to pay for graduate medical education in various settings.*

Three distinct approaches can be used to reduce variation in AAPCC-based rates. One would retain the current policy of setting local rates based on fee-for-service spending, but make technical improvements such as improving risk adjusters, adjusting claims data to reflect only patient care costs, and changing the geographic basis of local base rates.

The other approaches uncouple fee-for-service and risk payments. Among these alternatives, there are two types: those that build new payment rates from the AAPCC and those that discard the AAPCC altogether. Recent proposals by the Congress and the Administration contained examples of the former, including blending current local

## *Recommendations*

rates with national rates, trimming rates through floors (and ceilings), and setting new ways to update local rates.

*If the AAPCC is the base for setting rates that are unlinked from fee-for-service spending, then it would be appropriate to make technical improvements to the AAPCC.*

*Recommendation*

Proposals to replace the AAPCC altogether use competitive approaches to set payments, such as bidding or a defined contribution for both fee-for-service and risk beneficiaries.

*The Health Care Financing Administration should continue to test alternative methods for setting local payment rates, such as competitive bidding, partial capitation, and reinsurance.*

*Recommendation*

The present link between risk-plan payments and fee-for-service outlays has profound implications for Medicare spending growth. Increases in fee-for-service spending translate directly into higher risk-plan payments. To the extent that inadequate risk adjustment causes increased managed-care enrollment to raise AAPCC-based rates, Medicare spending may climb even more as risk-plan enrollment grows. As a result, promoting Medicare managed care without either improving technical aspects of current policy or unlinking risk payments from fee-for-service spending will lead to higher Medicare outlays.

How plans and beneficiaries react to payment changes is important. Their sensitivity to risk-plan payment rates will determine whether rate changes encourage or deter plan participation and beneficiary enrollment. Little is known about these relationships. Recent analyses show mixed results concerning the likely effect of payment rate changes. Unlinking risk payments from fee-for-service outlays will require more study of these responses in order to make accurate budget projections.

*The net effect of alternative policy combinations must be considered. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk-plan payments will differ, depending on the exact combination of policies used and the order in which particular elements are introduced. Any changes in payment policy will affect the relationship between Medicare managed care and fee for service with regard to per capita outlays, benefits, and premiums.*

*Recommendation*



*Changes should be designed and phased in to minimize disruptive effects on beneficiaries and plans.*

## *Recommendations*

*Expansion of Medicare managed care raises issues beyond setting payments to plans. The Commission reiterates its recommendations on the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures which were described more fully in its Annual Report to Congress 1996.*

## Implementing Risk Adjustment in the Medicare Program

Growth in Medicare managed-care enrollment has underscored the importance of risk selection and risk adjustment. Although current managed-care enrollees are healthier than average, Medicare payment rates reflect the costs of the average fee-for-service beneficiary. Risk adjustment—paying more to take care of the ill and less for the healthy—would reduce Medicare risk payments in the aggregate, focus competition on value rather than on selection, and encourage plans to enroll the chronically ill. Changes in payment levels would differ across plans, however, depending on the health status of their respective enrollee groups.

Moving forward with risk adjustment would significantly improve Medicare's payment methods and generate savings. Newer risk-adjustment methods appear to capture half or more of the potentially predictable variation in costs across groups, a dramatic improvement over the demographic risk-adjustment approach now being used. Better methods would save perhaps \$2 billion in excess payments that managed-care plans receive.

*The Health Care Financing Administration (HCFA) should adopt a new system for risk adjusting its payments to managed-care plans. As a first step, HCFA should immediately begin the phase-in of risk-adjusted rates by making modest payment changes using available Medicare administrative data and methods.*

## *Recommendations*

*Over the longer term, the data and infrastructure required to support risk adjustment based on the best available methods should be defined, developed, and implemented.*

*The Health Care Financing Administration should adopt new data reporting requirements consistent with the needs of the new risk-adjustment system. These requirements should include information on individual beneficiaries' diagnoses.*

Comparable data from the Medicare fee-for-service program and from managed-care plans are key to improving risk adjustment. Routine reporting of diagnoses based on encounter data for all beneficiaries is probably the best way to get this information. These data would be available for nearly everyone, would roughly match available fee-for-service claims data, and could be audited for accuracy.

The potential advantages of encounter data must be weighed against the significant costs to health plans for the data collection effort. In view of health plans' growing ability to provide such data, it may be more feasible for Medicare to obtain this information in the future. Procedures for obtaining data and ensuring their accuracy and validity will be needed.

Risk adjusters based on diagnosis information would not capture potentially important differences in functional health status. As an alternative, Medicare could survey beneficiaries concerning chronic conditions, health status, and functional disability, however. Self-reported data are roughly comparable to diagnosis data in predicting costs. Although payment rates derived from surveys would have an inherent degree of uncertainty because they are based on samples of beneficiaries, that could be addressed by paying plans through some blend of current rates and the risk-adjusted rates predicted by a beneficiary survey. HCFA could build on two current survey activities to gather needed data.

Because the extent of risk selection across plans is unknown, the distributional consequences of improved risk adjusters cannot be predicted. But since risk-adjustment methods typically underpredict the true variation in costs and selection, risk-adjusted payment rates would have a built-in conservative bias. Nonetheless, use of new data sources and the inability to predict the size of payment changes

warrant phasing in new payment rates based on new risk-adjustment methods.

*During the phase-in of risk adjustment, changes in plan payment rates should be limited to protect plans and the beneficiaries they serve from sharp swings in payment.*

*Recommendation*

Available administrative data could be used to set some modest differential payment adjustments across plans. For example, analysis of fee-for-service claims data reveals low costs for new managed-care enrollees prior to enrollment. Using these data to adjust plan payments would be preferable to an across-the-board cut in payments, such as that proposed in the President's budget, which could recoup excess payments but would not distinguish among plans or across geographic areas. In addition, hospitals are required to submit bills to HCFA for hospitalized managed-care beneficiaries, but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

*The Health Care Financing Administration should immediately enforce the existing requirement that hospitals report no-pay bills for hospitalized Medicare managed-care enrollees.*

*Recommendation*

There is little reason to wait for risk-adjustment methods to improve. Currently available methods capture a significant portion of the variation in costs across groups of beneficiaries. Phasing in any of the best available methods would result in a significant improvement in Medicare's approach to paying managed-care plans.

*The Health Care Financing Administration should now establish an orderly phase-in for all components of the risk-adjustment system, including data reporting, further development of risk-adjustment models, and implementation of adjusted payment rates.*

*Recommendation*

## Promoting Access to Care for Vulnerable Populations in Medicare Managed Care

Medicare managed care has the potential to increase access and improve care for vulnerable beneficiaries through coordination and



increased flexibility in the management and delivery of health services. But managed-care plans may be unwilling to reach out to these vulnerable groups or develop new approaches for serving them unless protected from the higher costs of their care and the possibility of incurring major financial losses.

Improving risk adjustment in Medicare capitation payment policy is critical for promoting access for vulnerable groups. Adequate risk adjustment would ensure that enrolling the most costly groups of beneficiaries does not lead to large plan losses.

*In developing improved risk adjusters, the Congress should direct the Health Care Financing Administration (HCFA) to recognize the importance of ensuring access for vulnerable groups in Medicare managed-care plans. As part of these efforts, HCFA should develop, evaluate, and implement risk adjusters that incorporate clinical diagnoses, functional status, and self-reported health status.*

## *Recommendation*

While risk adjustment would make payments more accurate, it would only partially shield plans from the costs of catastrophic cases. Another payment mechanism, risk sharing, would protect plans from the losses associated with exceptionally expensive patients. An outlier payment policy is one risk-sharing approach that would provide an additional retrospective payment to reimburse costs above a predetermined threshold. Though HCFA is currently testing this approach in a demonstration, Commission analyses suggest that risk adjustment is a superior method for improving payments.

Promoting access for vulnerable groups in Medicare managed care will require developing innovative health care strategies and evaluating whether they improve outcomes. Letting plans know about successes and failures will help successful strategies proliferate and deter unsuccessful ones.

The Medicaid program provides useful examples of policies designed to improve health care delivery for vulnerable groups enrolled in managed care. Approaches include strategies to foster smooth transition into managed care, maintain current provider relationships, and increase benefits for managed-care enrollees by promoting cost-effective care management.

*The Congress should direct the Health Care Financing Administration (HCFA) to pursue demonstrations of a broad range of innovative and effective health care delivery approaches for vulnerable groups in managed care. These demonstrations should identify approaches to provide care both within Medicare managed-care plans and through specialized arrangements when appropriate. HCFA should develop flexible funding mechanisms for these demonstrations, which might include higher capitation payments, risk sharing, and start-up funds.*

*The Congress should direct an agency, such as the Agency for Health Care Policy and Research, to develop a research framework for promoting access for vulnerable groups in Medicare managed care. In addition, the agency should coordinate public and private efforts to evaluate and disseminate innovative health care delivery strategies.*

## Access to Care in Medicare Risk Plans

Rapid growth in risk-plan enrollment and interest in restructuring Medicare increase the need to understand how beneficiaries fare in managed-care plans. To obtain information on access to care and to test methods for collecting this type of information regularly in the future, the Commission sponsored a survey of Medicare risk-plan enrollees and disenrollees. The Commission's study represents the most comprehensive, nationally representative survey of access in the Medicare risk program.

The survey findings were generally encouraging. The vast majority of enrollees had obtained care through their risk plan and had experienced no access problems. Most were satisfied with their care and with their plan. Beneficiaries enrolled because of the lower costs and enhanced benefits their plans provided. Three-quarters of enrollees paid no premium, and an even higher percentage received prescription drug benefits. Only 8 percent of enrollees had left their plans and, of those who did, more than half switched to another risk plan instead of returning to fee for service. Nearly all new enrollees said they received enough information to make them feel comfortable using their plan.

Although conclusive comparisons of access between Medicare fee for service and managed care cannot be made for various reasons, risk-plan enrollees apparently have had more access problems. Other studies are

needed to examine the extent to which perceived access problems are associated with inferior health outcomes. Policymakers should also recognize that changes in payment policy could affect plans' ability to offer beneficiaries increased benefits and reduced costs in exchange for some restrictions on access.

As is true in fee-for-service Medicare, vulnerable subgroups of risk-plan enrollees experienced access problems more often than other enrollees. These groups include the oldest old, those in fair or poor health, those in worsening health, and the nonelderly disabled. Overall, one in four enrollees would not recommend their plan to someone with a serious or chronic health problem.

Even though few beneficiaries had access problems, several survey findings deserve policymakers' attention. Although enrollees who switched health plans often sought enhanced benefits or lower costs, many who disenrolled to fee for service reported more access problems and were less satisfied than others. In addition, a third of enrollees did not know they had the right to appeal their plan's decisions about their health care.

Currently, there is no system for monitoring access in Medicare managed care as there is in for fee for service. As more beneficiaries choose managed care, it will become increasingly important for policymakers to have this type of information regularly available. The Commission's survey demonstrated that it is possible to collect timely information on access in managed care.

*The Department of Health and Human Services should monitor access to care under health plans participating in Medicare and report annually to the Congress on enrollees' access. Monitoring efforts should be designed to permit comparisons, where possible, of access between Medicare managed care and fee for service.*

## *Recommendations*

*Monitoring efforts should include analyses designed to explain access barriers for vulnerable groups and to determine the relationship between access and outcomes.*



# Using Quality and Performance Measures in Medicare

Private-sector purchasers increasingly use information on health plans' performance in administering their benefits programs. Many now use data on quality of care, access, member satisfaction, service use, costs, and other factors in making contracting decisions. Others use this type of information to steer enrollees to plans that appear to offer the highest levels of quality or value.

The Medicare program could also benefit from using quality and performance information. HCFA has taken steps to begin collecting this type of data on health plans participating in Medicare. The value of this effort will depend on how well quality and performance can be measured, and the extent to which this information can be used to promote value or quality-based competition among plans.

*Performance measures should now be used in Medicare to provide beneficiaries with information on participating health plans and, where comparable information can be obtained, on fee for service. The measures should also be used in Medicare's quality improvement program and in program monitoring.*

## *Recommendations*

*The Health Care Financing Administration (HCFA) should proceed in its use of Medicare performance measures as guided by advances in methodology and by considerations of public acceptance and private-sector use. HCFA should continue to collaborate with others to identify core measures to promote efficiency and minimize duplication of effort.*

HCFA should continue to work closely with others in the public and private sectors to refine approaches for using information to improve quality and to inform or protect beneficiaries. It should also take a leadership role in pursuing innovative strategies for presenting information to beneficiaries in accessible formats. As a public program, HCFA's efforts in this area could provide models for other purchasers or health plans seeking to inform consumers about their options.

Enhancement of Medicare's quality assurance program presents an opportunity to reevaluate the quality system and its components. One standard, the so-called 50-50 rule for enrollment composition, is arguably no longer needed in a Medicare program where more direct measures of health plan quality and performance are being

implemented. The rule, which prohibits a Medicare risk plan from exceeding a 50 percent cap on publicly insured (i.e., Medicare and Medicaid) enrollees, was instituted to increase plans' accountability and to serve as a quality proxy. At present, however, the rule creates barriers to plans' specializing in the treatment of the elderly and disabled, and restricts their Medicare participation and market expansion.

*The enrollment composition requirement (50-50 rule) should be dropped concurrent with implementing an enhanced quality assurance system that incorporates health plan performance measures. Plans should participate in an audited system of consumer-oriented performance reporting, maintain an internal quality assurance program, and be subject to external quality review by an independent entity approved by the Department of Health and Human Services.*

*Recommendation*

## Issues Concerning Data Reporting by Health Plans

As Medicare expands the range of plan options available to beneficiaries, data are needed to assess the quality, accessibility, and cost of the care that plans provide. These needs parallel those of individuals, accrediting bodies, and other public and private purchasers. Medicare also needs diagnosis and other information to risk adjust its payments to plans.

The current capabilities of health plans to collect data efficiently, however, vary considerably. Most plans are moving rapidly to develop encounter data collection capabilities, but the widespread implementation of comprehensive clinical information systems will take much longer. External data users, including Medicare, should cooperate with plans to develop information systems that meet everyone's needs.

*The Health Care Financing Administration (HCFA) should define a standard core health data set to meet Medicare's requirements for risk assessment and adjustment, quality improvement, access monitoring, and other performance measures. The cost of providing data should be weighed against the value of expected uses. The data set should be as consistent as possible with health plans' other internal and external*

*Recommendation*

*data needs. Once the core data set is well defined, HCFA should require health plans and their contractors to provide the necessary data.*

Medicare and others should consider several factors when asking for data from health plans. The uses of the information need to be carefully considered so that data collection processes can be designed appropriately. Effort must be devoted to making sure the data are as accurate, complete, and comparable across plans as is required by the expected use. Standardization is essential; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) assigns the federal government a key role in achieving uniform national data standards by the year 2000. As more health-related data are collected and exchanged, it will be increasingly important to safeguard the confidentiality of the information.

## Competitive Premium Contribution Models: Issues for Medicare

Both the Congress and the Administration have proposed offering Medicare beneficiaries a broader choice of health plans. Some policy experts have discussed one approach, a premium contribution system, that would significantly alter the way Medicare provides health care coverage for all beneficiaries. Instead of paying doctors and hospitals directly or contracting with a limited number of health plans, these systems provide a premium contribution that beneficiaries use to purchase coverage from among a variety of approved plans. The government would still specify the core set of benefits and apply financial solvency and quality standards to participating plans. Because such a system would be a significant departure from the current program, the Commission has begun to analyze these issues and their implications for Medicare.

A premium contribution system would shift Medicare's guarantee from a defined set of health care benefits to a defined contribution toward the purchase of coverage. Beneficiaries could have more choices but would assume the responsibility for premium costs that exceeded the government contribution. In theory, that would put strong pressure on plans to compete with respect to cost and quality, because plans with high premiums would risk losing enrollees to plans with lower



premiums or better quality of care. The government contribution could be set to guarantee access to a set of benefits and to at least one health plan.

Two commonly cited examples of premium contribution systems are the Federal Employees Health Benefits Program (FEHBP) and the California Public Employees' Retirement System (CalPERS). Both offer subscribers substantial choice among plans and have been able to control spending at least as well as any of their private-sector counterparts. FEHBP and CalPERS have made different decisions about key design features: the design of the contribution, the dynamics of the competition among plans, and the design of the benefit packages.

Premium contribution systems require trade-offs among competing goals. Maximizing beneficiary choice sometimes conflicts with minimizing growth in spending. In addition, attainment of these goals can be complicated by adverse selection and concerns about treating beneficiaries equitably in a system where different groups may pay different amounts for the same benefits.

Design of a premium contribution system for Medicare requires consideration of several additional design issues. A key decision is how to integrate current and future beneficiaries. At issue is the trade-off between changing the rules of the game for those people who have already contributed to the system during their working careers and maximizing savings to the program.

Second, choices must be made about whether to base the federal contribution on expenditures in Medicare fee for service or on the cost of providing coverage in different local markets. Maintaining a partial link to fee for service would ease a transition to a new system, but would not as accurately capture differences in local managed-care markets.

A third key issue is the generosity of the contribution. One approach is to set the contribution at or near the premium of the lowest-cost plan, since a low contribution is expected to maximize price competition. In the Medicare context, a contribution at that level would represent a significant cut in federal support. A higher contribution would maintain a consistent level of federal effort.

# Provider-Sponsored Organizations

In 1995, the Congress proposed allowing provider-sponsored organizations (PSOs)—health systems created through the formal affiliation of providers—to contract directly with Medicare. Several are now doing so as part of HCFA's Medicare Choices demonstration project. Considering a broader role for PSOs in Medicare raises questions about how plan standards should be applied and how to protect consumers from the consequences of plan insolvency.

States regulate insurers and HMOs to ensure quality and protect consumers. A key decision they face is whether to regulate PSOs under the same rules that apply to HMOs. States are taking three different approaches when deciding whether and how to license PSOs: (1) applying existing laws and regulations to them, (2) developing new rules for overseeing PSOs, and (3) creating a new regulatory system that applies to all entities accepting risk.

Policymakers have been particularly concerned about protecting consumers from the consequences of plan insolvency. In applying HMO standards to PSOs, issues to be resolved include whether solvency standards should be lower than for HMOs and the extent to which health care delivery assets could be used to satisfy solvency requirements.

States also require plans to protect consumers from the adverse consequences of plan failure by having insolvency insurance and indemnifying beneficiaries from financial liability in the event of plan insolvency. These measures appear equally appropriate for PSOs as for other types of plans.

In 1995, different versions of Medicare restructuring legislation provided special treatment for PSOs by waiving state licensure requirements and applying federal solvency standards. Since then the environment has changed. New PSOs are succeeding in many markets, and states are starting to revise laws to ensure that PSOs do not face barriers to entry. The National Association of Insurance Commissioners is moving forward with model laws that could be adopted by the states. These trends seem to reduce the urgency of special treatment for PSOs under Medicare.

*Provider-sponsored organizations that participate as risk contractors in the Medicare program should be required to meet the same standards as other plans. Flexibility should be used in developing and enforcing standards and rules as appropriate given differences in plan design.*

*Plan participation in Medicare should be monitored to ensure that state or federal requirements do not impose unreasonable barriers to market entry for provider-sponsor organizations or other health plans seeking to participate in Medicare.*

In implementing the principle of treating all types of plans equally, policymakers may consider options that include requiring all plans to be licensed by their states or making plan standards solely a federal responsibility for all types of plans. Elimination of the enrollment composition requirement (the 50-50 rule) may also affect how standards are enforced in the future.

## Consumer Protection Initiatives for Managed Care

The rapid growth of managed care has been accompanied by calls from consumer and provider groups for more stringent oversight and regulation. In response, policymakers in nearly every state with a significant managed-care presence have considered new laws or regulations that would govern managed-care plans.

Since the Commission last addressed these issues in its 1995 annual report, there has been an unprecedented increase in legislative activity in federal and state governments. More than 400 bills designed to curb perceived problems with managed care were introduced in state legislatures in 1996—twice as many as in 1995. More than half of the states passed some form of managed-care consumer protection legislation. While most legislative action has occurred at the state level, both the Congress and the Administration have given greater attention to these issues in the past year. Initiatives at both the federal and state levels generally have focused on specific issues (such as maternity length-of-stay provisions), although several states have passed comprehensive consumer protection laws.

Because most of these activities are new, it is too soon to determine how they have affected managed-care plans or enrollees. The



Commission will continue to monitor the development, implementation, and enforcement of these initiatives.

## Constraining Spending in Medicare Fee for Service

The continued rise in Medicare fee-for-service spending has serious implications for both the program and the federal budget. Currently, the Congressional Budget Office projects that Medicare spending will continue growing by rates of 8 percent to 9 percent annually. The Congress sought to curb similar high rates of spending growth for physicians' services in the late 1980s through the Volume Performance Standard (VPS) system.

A budgeting tool like the VPS system is necessary to constrain spending for physicians' services, but methodological flaws keep the system from working as intended. The Congress and the Administration have proposed a revision to the VPS system, called the sustainable growth rate system, which would incorporate many of the Commission's previous recommendations to correct these limitations.

This new system would establish a single conversion factor, update, and performance standard for all physicians' services covered by the Medicare Fee Schedule. That would eliminate current distortions caused by separate standards and updates for different categories of services. The proposed change would, however, require a large reduction in payment for surgical services. Because current law calls for the implementation of resource-based practice expense relative values in 1998, another substantial reduction in payment is expected for surgical services.

*A single volume performance standard and update for all categories of physicians' services should be adopted. The transition to a single conversion factor should occur over a three-year period and should be coordinated with the implementation of resource-based practice expense relative values to prevent large payment reductions for any category of service in a single year.*

### *Recommendation*

Under the current policy, the VPS system will set increasingly unrealistic target rates of spending growth. The sustainable growth rate system would resolve that by setting a target linked to growth in gross

domestic product, instead of the five-year historical trend for volume and intensity growth of physicians' services and a 4 percentage point deduction.

*Current policy, which sets the performance standard for physicians' services using the historical trend in volume and intensity growth and a 4 percentage point deduction, should be replaced by a formula linked to the projected growth of real gross domestic product per capita. In addition, estimates of this growth should be increased by 1 or 2 percentage points to allow for advancements in medical capabilities.*

## *Recommendation*

To avoid large fluctuations in the annual updates, the sustainable growth rate system should incorporate limits on the size of the conversion factor updates. The President's fiscal year 1998 budget proposes that budget updates should not be more than 3 percentage points above the Medicare Economic Index or fall more than 8.25 percentage points below it. The Commission favors a more narrow and symmetric range.

*When setting the annual conversion factor update for physicians' services, symmetric limits should be established to restrict reductions and increases to within 5 percentage points of the Medicare Economic Index.*

## *Recommendation*

Developing a mechanism to slow overall Medicare spending growth presents additional challenges. Spending growth for some sectors continues unabated. Currently, only payment policy for physicians' services incorporates a mechanism that links payment levels to volume and intensity growth. Some sectors have mechanisms to curb price, but lack volume constraints. Other sectors have payment policies that affect neither price nor volume. Developing constraints for spending growth in other sectors is difficult, however, since physicians often determine service use in these sectors but are not affected by reductions in other providers' payments.

Expenditure targets and expenditure limits are two general strategies for constraining fee-for-service spending. An expenditure target system establishes a level of spending, and then adjusts payments up or down so that, on average over time, spending matches the planned budget trajectory. The VPS system for physicians' services is an example of an expenditure target policy. An expenditure limit system sets a ceiling for spending and only adjusts payments downward as needed when

spending exceeds the limit. If spending falls below the limit, payments are not adjusted and the shortfall is garnered as additional savings to the Medicare program. The failsafe budget mechanism proposed in the Balanced Budget Act of 1995 is an example of an expenditure limit system.

Developing a system of expenditure targets or expenditure limits for the Medicare program raises difficult design issues about appropriate levels of spending and appropriate spending allocations for each service sector. In addition, any system's design should allow for the inherent volatility in year-to-year spending.

## Medicare Fee Schedule Payment Issues

With the completion of the transition in 1996, the Medicare Fee Schedule is now the sole basis for Medicare payments to physicians. On average, Medicare's payment per service decreased by 2 percent between 1995 and 1996. The decline was influenced by completion of the transition to fee schedule payments and relatively low conversion factor updates for 1996.

Important refinements to the fee schedule are still taking place, improving its accuracy in reflecting the relative resources required to provide each service. The most controversial of these is the development of resource-based practice expenses to be implemented in 1998. Concerned that HCFA has not gathered enough data to calculate appropriate new values by then, some are urging a one-year delay in implementation. The Commission disagrees. The move from charge-based to resource-based practice expense relative values is long overdue. HCFA has enough information to develop initial values by the deadline, and a year's delay will not produce new information to facilitate the process.

*Resource-based practice expense relative values should be implemented in 1998 as scheduled. The Congress should revise current law so that the new values are phased in over three years, The Health Care Financing Administration should develop a process to refine the initial values. The refinement process should include input from interested parties, as occurred when physician work values were first introduced. The process*

*Recommendation*



*should be announced when proposed values are released for public comment.*

If implementation should be delayed despite the Commission's recommendation, the duration of the proposed transition should be shortened accordingly.

When resource-based practice expense relative values are implemented, malpractice expense will be the only component of the relative value scale still based on historical charges.

*The Congress should revise current law so that the malpractice expense component of the Medicare Fee Schedule will be resource based. The Health Care Financing Administration should be directed to collect data on risk groups and relative insurance premiums across insurers that can be used to develop new malpractice expense relative values.*

## *Recommendation*

Refinements to relative work values during the five-year review made them more accurate, though there are still some outstanding issues. The Commission and others are beginning to look at how the process can be improved for the next review.

HCFA also revised the fee schedule payment areas during 1997. This revision changed the geographic adjustment factors and represented an improvement over the original areas. Certain limitations of HCFA's method concern the Commission, however. The agency's approach may create significant payment differentials in metropolitan areas and does not allow for dividing larger payment areas into smaller ones if demographic and economic changes so warrant.

## Access and Beneficiary Financial Liability under the Medicare Fee Schedule

The Commission is mandated to monitor beneficiary access under the Medicare Fee Schedule and to recommend measures to address any problems with access or financial protection. In fulfilling its charge, the Commission considers many dimensions of access that shape beneficiaries' experiences in obtaining care. The Commission's

complete analysis of access and financial liability will be reported to the Congress in May.

The Commission has consistently found that access remains good for most beneficiaries. Decreases in selected services appear related to changes in treatment modalities or other factors, rather than to changes in payment policy. Beneficiaries report no increases in problems obtaining care and their satisfaction with care continues to be high.

The Commission's most recent claims analyses show that growth in beneficiary use of services is low. Use of some services, including office and other outpatient visits, mammography, and electrocardiograms, decreased between 1995 and 1996. Although the decreases were small, they warrant further monitoring and analysis to determine whether declines occurred for services identified as clinically necessary for care of specific conditions.

Some groups of vulnerable beneficiaries—including African Americans and those without supplemental insurance—have more access problems than others, however. The Commission's analysis of the Medicare Current Beneficiary Survey shows that several factors, including self-reported health status, are associated with these problems.

As for beneficiary financial liability, physician participation in Medicare and acceptance of assignment continue to grow. In 1995, 96 percent of physician claims were paid on assignment. Moreover, mandated limits on balance billing appear to be working. Charges above the limit have declined; those exceeding it do so by relatively small amounts. While these indicators are encouraging, policymakers need to understand the burden that out-of-pocket spending for Medicare cost sharing and noncovered services places on different types of beneficiaries.

Future changes in payment policy and the health care market may affect beneficiary access. Under the current VPS system, physicians could face substantial lower payment levels in the near future. Changes in VPS policy could affect physicians differently, depending on the mix of services they provide. Implementation of resource-based practice expense relative values will reduce payments for some services but raise them for others. More broadly, changes in the health care market,

including the growth of managed care, could influence access under Medicare fee for service.

## Private Secondary Insurance for Medicare Beneficiaries

Roughly 87 percent of Medicare beneficiaries have health insurance to augment their Medicare coverage. Over 70 percent have private supplemental coverage, either individually purchased Medigap insurance or employer-provided retiree health benefits. Employer-provided supplemental insurance is often more generous than Medigap insurance, although it may require some beneficiary cost sharing. Future policy changes to the Medicare program may influence how employers deliver retiree health benefits.

Private supplemental insurance provides valuable financial protection to Medicare beneficiaries and is associated with better access to care for those beneficiaries who have it. By insulating beneficiaries from the cost of the care they use, however, secondary insurance also increases utilization and Medicare spending. Expenditures for beneficiaries with no supplemental coverage or employer-sponsored coverage were nearly 28 percent less and 10 percent less, respectively, than expenditures for beneficiaries with Medigap insurance.

Medigap insurers and Medicare risk plans operate under different rating, underwriting, and portability standards. These differences create barriers for beneficiaries wishing to change among supplemental and basic Medicare options, causing some beneficiaries to purchase supplemental insurance needlessly. Expanding portability in the supplemental insurance market could mitigate these barriers, foster competition, and remove incentives for beneficiaries to purchase redundant coverage. It could also have implications for adverse selection, Medigap premiums, and Medicare program costs.

In 1990, the Congress authorized network-based supplemental insurance products known as Medicare SELECT. Like preferred provider organizations, SELECT plans are intended to save Medicare money through beneficiary use of carefully chosen networks of high-quality, cost-effective providers. A program evaluation, however,



showed mixed results. Medicare SELECT plans had no clear effect on Medicare expenditures. Evaluators were hampered by their inability to obtain information on many beneficiaries' prior supplemental insurance status.

*Insurers and employers that provide insurance which supplements basic Medicare benefits should be required to report information about beneficiaries' purchase or receipt of such insurance to the Health Care Financing Administration.*

## *Recommendation*

# The Changing Labor Market for Physicians

With policymakers focusing on the potential benefits of a more competitive health care market, some argue that market forces will resolve the problems of physician oversupply and specialty imbalance. In theory, the growth of cost-conscious integrated health systems will alter the number and mix of services used by patients and thus the number and mix of health professionals needed to provide those services. These developments could, in turn, lower physicians' earnings or prevent them from finding jobs in medicine, thus sending a signal to students and educators to change their behavior.

The Commission has examined whether changes in the organization and financing of health care are affecting the physician labor market. It looked at two types of change: whether higher demand for primary care physicians is leading to changes in specialty mix, and whether the market is creating incentives to train fewer physicians overall. Previous Commission work found that market changes were more modest than suggested by anecdotes.

A review of more recent data produced more ambiguous findings. While it appears that specialty mix is changing in response to increased market demand for primary care physicians, there seems to be a continuing strong demand for physicians in highly specialized fields. In addition, the indicators concerning aggregate supply do not suggest there is an oversupply of physicians. Changes in the market do appear to be affecting the conditions of employment for many physicians, however. Because most data sources are national, it is difficult to tell whether changes are more accentuated in more competitive markets.

# Academic Medical Centers and the Changing Health Care Marketplace

Traditionally, academic medical centers (AMCs) have supported their missions—education of health professionals, biomedical research, and patient care (particularly to the uninsured)—through a complex system of cross-subsidies. This financing method may no longer be tenable, however, as managed-care plans appear less willing than indemnity insurers to pay higher fees for care in academic settings and budget crises at the local, state, and federal levels threaten ongoing government support.

Academic medical centers are responding to these changes by significantly modifying their operations to increase their efficiency and secure market share. They are also voicing their concerns about the future to policymakers at federal and state levels in an effort to sustain or expand government support.

In the Commission's view, action by federal policymakers to intervene on behalf of academic medical centers would be premature. First, managed-care plans are contracting with AMCs for both specialty and primary care services, although there is some evidence that they are steering their enrollees elsewhere. Second, despite signs of financial stress, AMCs as a group do not seem to be in worse condition than other hospitals due to increased competition. Third, hospital margins for teaching hospitals also indicate strong performance. Finally, while a few AMCs are downsizing their training programs, their reasons for doing so are unclear. There is some anecdotal evidence, however, that stepped-up competition in the health care market is squeezing the ability of AMCs to conduct basic and clinical research.

Despite the uncertainty about their future, most AMCs are actively working to position themselves for survival in a more competitive marketplace. Strategies being pursued include reducing operating expenses, undergoing hospital conversions and mergers, creating integrated systems, and developing new products and markets. Because of the special roles these institutions play, it will be important to continue monitoring how market changes are affecting them.

# Financing Graduate Medical Education and Teaching Hospitals from a Trust Fund

Since 1990, the Commission's mandate has included a provision to review and consider Medicare payments for graduate medical education and the supply and specialty distribution of physicians. In 1997, the Congress continues to be interested in reforms in Medicare payments for GME. Policymakers are focusing on how to change Medicare policies to make them more rational, equitable, and less of an impediment to change as educators seek to adapt graduate medical education to changes in the nation's health care system.

One approach to reform is to place Medicare revenues in a trust fund from which payments could be made to entities involved in training based on principles other than hospital costs and admissions. The first step policymakers must make in evaluating the merits of a trust fund is to determine the purpose of such support. All other decisions (for example, who can get the money and how much they are eligible to receive) should flow from a common understanding about these purposes.

There are at least three different reasons for Medicare to provide special support for teaching hospitals: to ensure beneficiary access to these facilities, to safeguard the viability of teaching hospitals, and to ensure a physician work force to meet Medicare beneficiaries' needs. A case can also be made that there is no compelling rationale for continuing Medicare support of GME.

Using sources other than Medicare to finance graduate medical education raises a host of questions. One is whether there is a different rationale for financing teaching hospitals or GME from general revenues (or other payers) than from Medicare dollars. Another is whether such differences imply different principles for distributing funds. Medicare's current commitment to GME is made in the context of the total amount of money Medicare has available to spend on all aspects of the program. Appropriately, therefore, Medicare GME payments are related to each institution's Medicare caseload. General revenues, by contrast, could be distributed among training programs and teaching hospitals using whatever criteria the Congress finds compelling.



There are several implications of financing graduate medical education and teaching hospitals from a trust fund. First, the existence of a trust fund creates an opportunity to correct several flaws in current policy. Second, the trust fund shifts financing from an open-ended entitlement to a fixed pool. Third, financing from general revenues creates a new political dynamic for stakeholders. Finally, the existence of a trust fund creates an administrative structure that could be used for accepting and distributing revenues from other payers.

As the Commission works with the Congress in the coming months, it will continue to explore the implications of financing GME and teaching hospitals through a trust fund. Issues to be considered include which entities should be eligible to receive trust fund payments and methods to ensure their accountability, the implications of paying hospitals based on their historical share of Medicare dollars, and how to set allocations to accommodate future changes in training venues.

## Managing Health Care for Dually Eligible Beneficiaries

More than 5 million elderly and disabled persons are jointly enrolled in Medicare and Medicaid, and thus entitled to receive benefits from both programs. These beneficiaries, known as dual eligibles, have only recently begun to receive attention in Medicare and Medicaid policy discussions.

***Development of proposals to restructure Medicare and Medicaid should explicitly take into account their implications for disabled and elderly beneficiaries who are entitled to benefits from both programs. Proposals should be assessed in terms of their effect on the potential for coordinating the financing and delivery of care.***

### *Recommendation*

For those who are dually eligible, Medicare is the primary insurer, providing coverage for most inpatient care and physician visits. Medicaid furnishes cost-sharing protection for dual eligibles and covers certain benefits Medicare does not.

As the congressional debate continues, policymakers should consider several characteristics of this vulnerable population. As a group, they are more likely than other Medicare beneficiaries to be disabled,

functionally impaired, among the oldest old, and institutionalized. They also account for a disproportionate share of Medicaid spending.

While managed care offers new opportunities for serving these beneficiaries, such arrangements also create challenges for Medicare, Medicaid, beneficiaries, and plans. As states shift more and more Medicaid beneficiaries to prepaid care—and as Medicare managed-care enrollment increases—dually eligible beneficiaries may have to get their care through an increasingly complex array of arrangements. With Medicaid waivers, states can test innovative ways to meet the special health care needs of this group. But coordinating care between the two payers may be difficult, especially if beneficiaries must use two different delivery systems.

Several other problems may arise in providing managed care for dual eligibles. First, there may be an incentive for providers or plans to cost shift between Medicare and Medicaid by substituting services paid under fee for service for prepaid care. Second, there are minimal incentives for Medicare or Medicaid to use care-management initiatives expected to yield savings in the other program. Finally, barriers like incongruous participation requirements may prevent health plans from serving both Medicare and Medicaid beneficiaries, and thus from being able to provide the full range of needed services.

Coordination of initiatives at the state and federal levels will undoubtedly influence the care delivered to the dually eligible population. HCFA has worked with others to devise a framework to guide states in planning and implementing programs to serve this group, and further steps could be taken. One is to reduce the barriers posed by the inflexibility of Medicare risk-program requirements. Another is to make Medicare and Medicaid risk-program participation standards more comparable. Legislation increasing the scope of HCFA's authority to approve Medicare waivers could also be valuable. Finally, demonstrations combining federal and state financing for the care of dual eligibles could provide insight into improving service delivery.

*The Health Care Financing Administration, in conjunction with state Medicaid agencies, should develop and test improved ways to coordinate the financing and delivery of care for beneficiaries eligible for both Medicare and Medicaid. Promising approaches should be tested through demonstration projects and results disseminated.*

## *Recommendation*

# Medicaid: Spending Trends and the Move to Managed Care

During its last session, the Congress considered changes in the Medicaid program to limit growth in spending and permit more innovation in service delivery and payment policy. Although no Medicaid legislation was enacted, passage of welfare reform will affect Medicaid because of the historical link between Medicaid eligibility and welfare eligibility.

Large projected spending increases have been a key factor driving Medicaid reform initiatives. New projections that spending will grow at less than 8 percent annually (compared with 22 percent between 1988 and 1992) appear to be reducing pressures for change.

States are also making extensive changes in their Medicaid programs, particularly by moving more beneficiaries into managed-care plans. While fewer than 300,000 Medicaid beneficiaries were enrolled in managed care in 1981, in 1996 this level had increased to 9 million in full-risk managed-care plans and to nearly 13 million in any type of managed care. These estimates are lower than HCFA's because they do not count enrollment of beneficiaries in carve-out plans covering only a small portion of Medicaid's benefit package.

States that have moved actively into Medicaid managed care have made a number of different decisions about rules for enrollment and disenrollment, marketing, plan selection, and setting capitation payments. Examination of these decisions can inform policy development both for other states and for the Medicare program as it expands the range of choices available to its beneficiaries. In some cases, the Medicaid experience appears to reinforce the Commission's previous conclusions, for example, that the availability of comparative information on plan options is critical for beneficiaries to make meaningful choices among competing plans. In other areas, the Medicaid experience may offer insight into issues like the use of enrollment brokers, where the Medicare program lacks experience.





# The Context for Medicare and Medicaid Policy

**I**n the mid-1980s, when the Physician Payment Review Commission was created, traditional indemnity insurance was the predominant form of coverage in the Medicare and Medicaid programs as well as in the private sector. Congressional action affecting Medicare, including major reforms in hospital and physician payment, assumed that fee-for-service medicine would remain the principal form of health care financing and delivery well into the future.

Since then, the American health care system has changed dramatically. The number of people covered by indemnity insurance has declined rapidly, while the number of those in managed-care plans has grown. Managed-care plans have also developed quickly, evolving toward more integrated systems and closer relationships with their provider networks. Physicians and hospitals have been joining to form new types of health care organizations. Rising health care costs have raised concerns about our society's ability to sustain such growth in the future. In the private sector, leading corporate purchasers of health care are responding to rising premiums by changing the way they pay for health services, potentially affecting both the cost and quality of care.

Rising costs have also created challenges for Medicare. Despite relative success in controlling spending growth for physicians' and hospital services, expenditures for other types of Medicare-covered services have been increasing rapidly. Recent debate has centered on whether price or volume constraints can hold down spending in a fee-for-service system or whether a more fundamental restructuring of Medicare, consistent with

movement toward managed care in the private sector, is necessary. Of late, slowing premium growth in the private sector has created expectations that greater managed-care enrollment in Medicare will moderate future spending increases. Furthermore, introducing more innovative methods of service delivery and payment than are permitted under current Medicare law may result in better matches between program offerings and consumer preferences.

Medicaid poses federal and state policymakers with a different set of challenges. More than half of all Medicaid expenditures are paid for by the federal government, making the program a target for those seeking to reduce federal spending. These efforts have focused primarily on limiting the federal government's maximum liability for Medicaid costs. Similarly, states are concentrating on ways to curb Medicaid spending, which is a major component of their budgets. Many are restructuring the delivery of Medicaid benefits, attempting to make these costs more predictable. A number of states have applied for waivers of federal requirements that can allow them to increase enrollment of Medicaid beneficiaries in managed-care plans.

Dually eligible beneficiaries—those beneficiaries who receive both Medicare and Medicaid benefits—pose unique challenges to state and federal policymakers seeking to coordinate the care, benefits, and financing provided through the two programs. Federal and state reforms affecting Medicare and Medicaid may have important consequences for this population. How these beneficiaries will be affected must be considered as these programs are modified.

This chapter describes the policy context in which the Medicare and Medicaid programs function and outlines some of the challenges facing policymakers as they seek to modify these two programs. First, the benefits provided and beneficiaries served by the two programs are described. Trends in national health, Medicare, and Medicaid expenditures are highlighted, and spending growth in Medicare and the private sector are compared. Issues raised by the rapidly changing health care marketplace are also outlined.

## **MEDICARE: BENEFITS AND BENEFICIARIES**

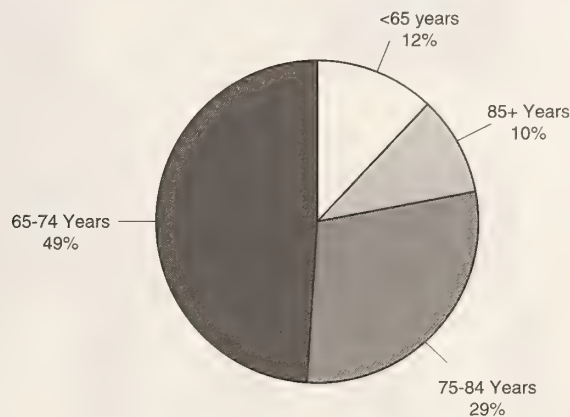
Medicare provides its beneficiaries with basic health insurance and is divided into two parts. Enrollment in Part A (hospital insurance) is automatic; it covers inpatient hospital care, skilled nursing facility care, home health and hospice care. Payroll taxes paid by active workers and their employers finance this portion of the program. Part B (supplemental medical insurance) is voluntary and covers physicians' services, laboratory services, outpatient hospital care, and some home health care and medical supplies. It is financed through premiums paid by beneficiaries (\$43.80 per month in 1997) and by general tax revenues. Medicare beneficiaries can elect to receive their benefits either through the traditional fee-for-service program or through enrollment in a managed-care plan that has a contract to serve Medicare beneficiaries.



## Medicare Beneficiary Profile

In 1996, Medicare provided basic health insurance to more than 38 million Americans (roughly 14 percent of the population). People qualify for Medicare if they are 65 or over, disabled, or have end-stage renal disease (ESRD). Nearly 9 in 10 beneficiaries are elderly, while the rest are either disabled or have ESRD (HCFA 1996). In 1995, 10 percent of the Medicare population was 85 or older (Figure 1-1). Over time, the oldest old, the disabled, and those with ESRD are expected to represent an increasing proportion of the Medicare population.

**Figure 1-1. The Composition of the Medicare Population by Age, 1995 (percentage)**



SOURCE: HCFA 1996.

Medicare spending is unevenly distributed among beneficiaries. In 1993, for example, nearly two-thirds of beneficiaries had Medicare expenditures of \$1,000 or less. By contrast, only 5 percent of elderly beneficiaries were responsible for more than 50 percent of Medicare spending in that same year (Figure 1-2) (HCFA 1996).

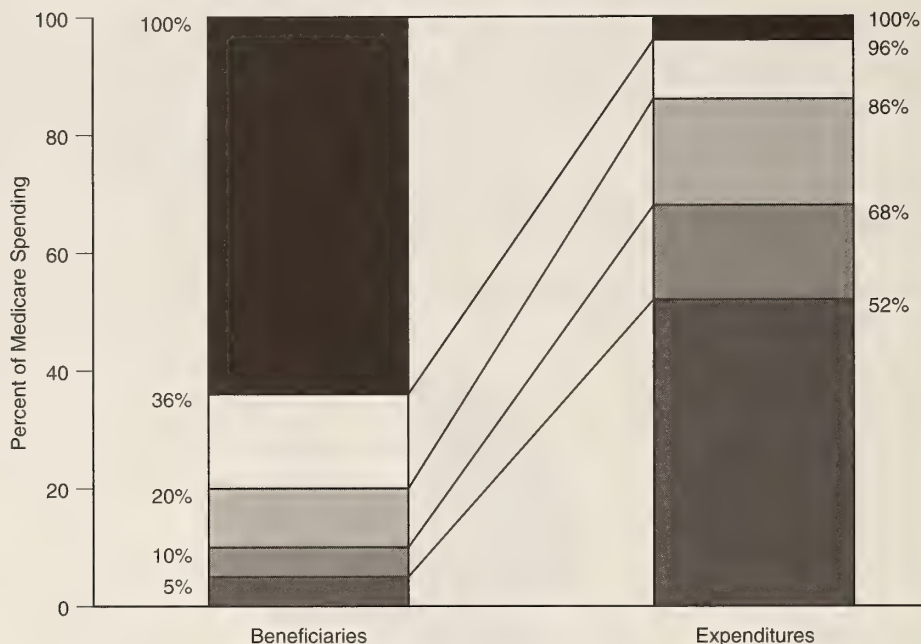
## Beneficiary Financial Liability

Most Medicare beneficiaries have limited incomes. In 1993, close to three-quarters of elderly beneficiaries reported annual household incomes of less than \$25,000, and just over half of disabled beneficiaries reported annual incomes of less than \$10,000 (Figure 1-3) (HCFA 1996).<sup>1</sup> Medicare is extremely important to these beneficiaries because it allows them to seek care that they might not otherwise be able to afford. In 1993, per capita Medicare expenditures were \$4,083, a significant portion of the annual income of most beneficiaries (Levit et al. 1996a). Without Medicare, it is likely that most beneficiaries would have been unable to afford at least some of these services.

---

<sup>1</sup> In 1995, the poverty threshold for a single person over 65 was \$7,309. In the same year, the poverty threshold was \$9,219 for an over 65 two-person household, and \$7,929 for a single person under 65. Although there are perceptions that many Medicare beneficiaries are financially well-off in terms of assets, most beneficiaries have limited assets. Some beneficiaries do have extensive assets, but relatively few beneficiaries fall in the middle. According to data from 1994, roughly 26 percent of elderly households had annual income from assets of less than \$250 per year (Social Security Administration 1996).

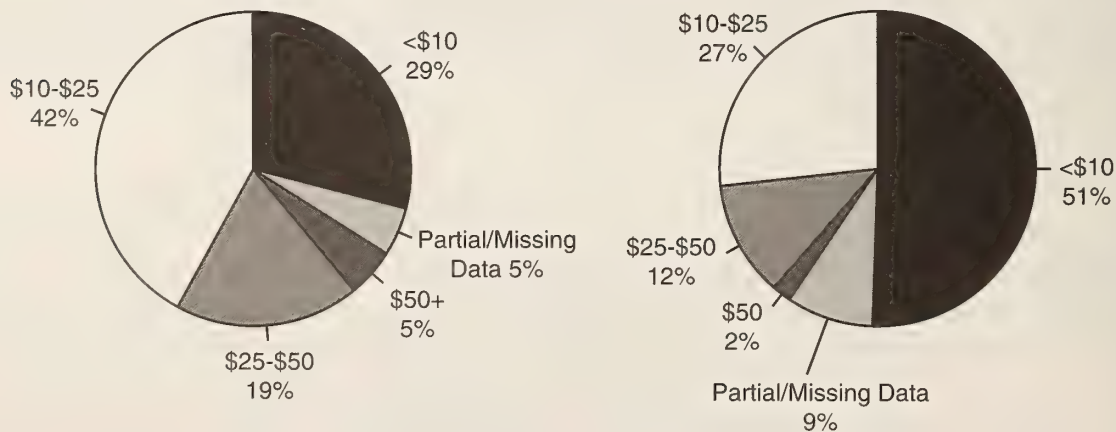
**Figure 1-2. Distribution of Medicare Spending for Elderly Beneficiaries, 1993 (percentage)**



SOURCE: HCFA 1996.

NOTE: These data do not include HMO enrollees.

**Figure 1-3. Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1993 (thousands of dollars)**

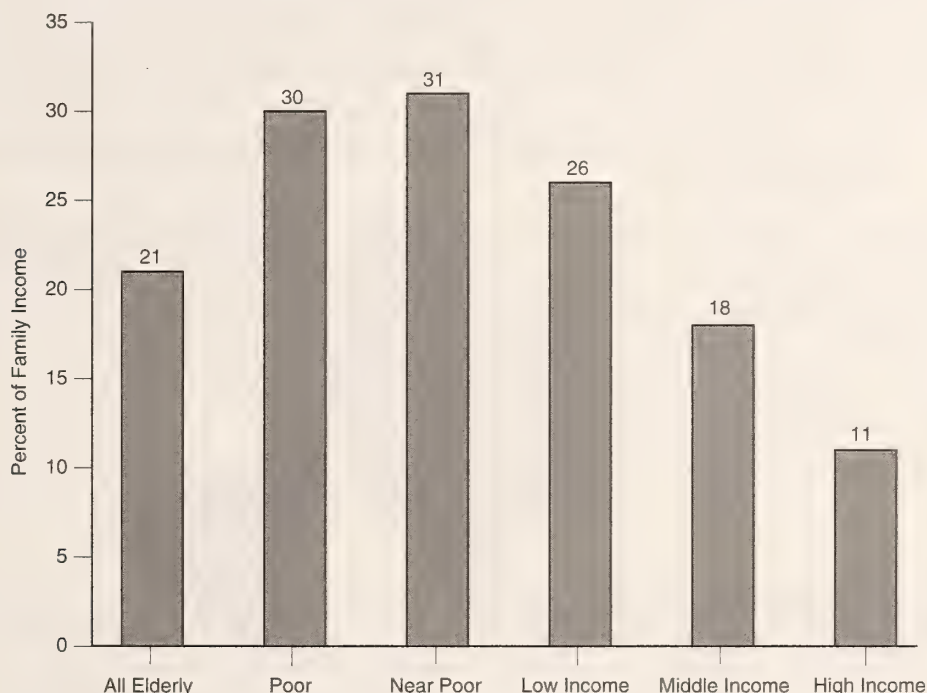


SOURCE: HCFA 1996.

NOTE: Income represents total gross income, and includes pensions, Social Security Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, Veterans Administration and workers' compensation benefits; interest, dividends, and work-related income.

Even with Medicare coverage, beneficiaries have significant financial responsibilities for the costs of their care. They are responsible for some Part A and Part B copayments and deductibles.<sup>2</sup> They also must pay for physician charges in excess of the Medicare Fee Schedule amount and for services like prescription drugs, eyeglasses, and long-term care, which Medicare does not cover. In 1996, elderly Medicare beneficiaries spent, on average, 21 percent of their income on out-of-pocket medical expenses, including the Part B premium (Figure 1-4) (Moon et al. 1996).

**Figure 1-4. Out-of-Pocket Health Spending for the Noninstitutionalized Elderly as a Percent of Family Income, 1996**



SOURCE: Moon et al. 1996.

NOTE: The poor are those with incomes at 100 percent or less of the poverty level; the near poor are those between 100 and 125 percent of poverty; low income are those between 125 and 200 percent of poverty; middle income are those between 200 and 400 percent of poverty; and high income are those with incomes over 400 percent of poverty.

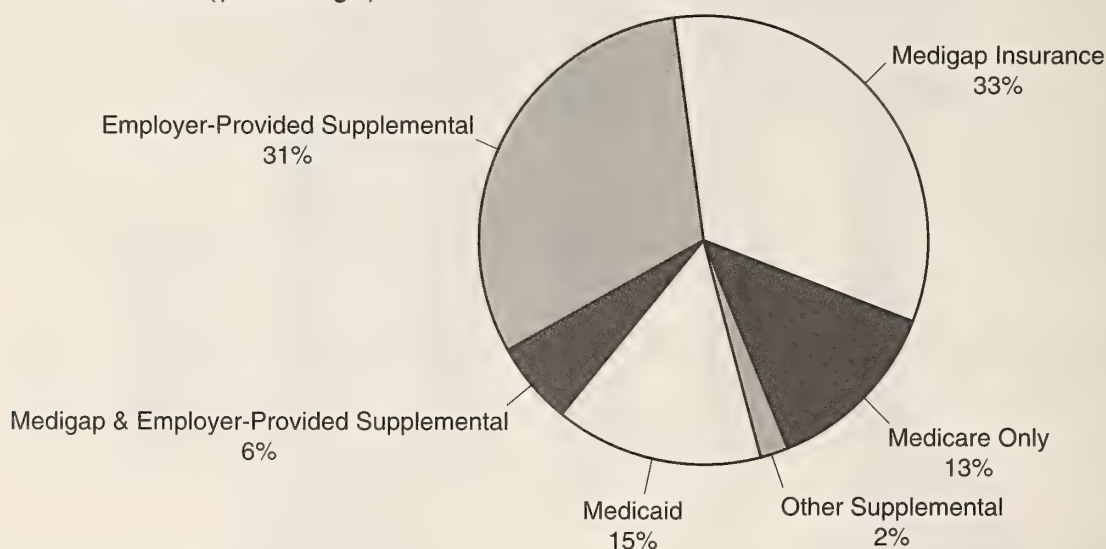
Cost-sharing burdens, like Medicare expenditures, are highly concentrated among the most severely ill. For example, out-of-pocket expenses for Medicare-covered services among the 10 percent of the Medicare population with the highest health care costs were roughly \$5,600 per beneficiary in 1996. In the same year, 20 percent of beneficiaries had no cost-sharing expenses (Moon 1996). Unlike most employer-provided health insurance, Medicare has no maximum out-of-pocket spending limit.

<sup>2</sup> In 1997, copayment requirements include 20 percent of allowable physician charges, hospital copayments of \$190 per day for days 61-90 in the hospital and \$380 for each lifetime reserve day, and \$95 per day for days 21-100 of skilled nursing facility care. Deductibles in 1997 are \$100 annually for Part B and \$760 per hospital stay for Part A.



Because of these potentially unlimited out-of-pocket expenses and gaps in Medicare coverage for certain items and services, the vast majority of fee-for-service Medicare beneficiaries (roughly 87 percent in 1995) have some form of supplemental insurance to augment their Medicare benefits. About one-third buy private supplemental insurance (called Medigap insurance) to cover many of these costs. Another 31 percent have employer-provided insurance that covers Medicare cost sharing and some noncovered services; roughly 6 percent have both Medigap and employer-sponsored coverage. Some 15 percent of beneficiaries in fee-for-service Medicare also have Medicaid coverage (Figure 1-5). Supplemental insurance provides valuable financial protection to beneficiaries who have it. But, with the exception of Medicaid and some employer-sponsored coverage, beneficiaries must pay for this coverage themselves. Inasmuch as average annual Medigap premiums exceed \$1,200 and premiums for employer-sponsored coverage are approaching \$1,000, these costs are significant.<sup>3</sup>

**Figure 1-5. Supplemental Insurance Status of Beneficiaries in Medicare Fee for Service, 1995 (percentage)**



SOURCE: Physician Payment Review Commission analysis of the 1995 Medicare Current Beneficiary Survey.

## MEDICAID: BENEFITS AND BENEFICIARIES

The Medicaid program is a jointly financed federal-state health insurance program that provides basic health care coverage to people who meet eligibility requirements related to income, age, family composition, and disability status. Medicaid covers three basic categories of beneficiaries: the aged, the blind and disabled, and members of families with dependent children. Beneficiaries qualify either because they are categorically eligible or medically needy, although specific eligibility requirements

<sup>3</sup> The lower out-of-pocket premium costs for employer-provided supplemental insurance are offset, in many cases, by deductible and cost-sharing requirements.

vary from state to state. Services covered by Medicaid also vary by state, but must include hospital and physicians' services; laboratory and X-ray services; nursing home and home health care; and early and periodic screening, diagnosis and treatment, or EPSDT, for children under age 21. States may elect to cover other services such as prescription drugs, clinic services, hearing aids, and intermediate care facilities for the developmentally disabled.

In 1995, Medicaid provided health insurance coverage to about 35 million beneficiaries (about 13 percent of the U.S. population) at a cost of just about \$150 billion. Of these beneficiaries, roughly 17 million were children in low-income families, 8 million were adults in low-income families, 6 million were disabled, and 4 million were elderly (Kaiser Commission 1997). As of 1995, more than 5 million beneficiaries (all elderly and some disabled Medicaid beneficiaries) also qualified for Medicare. These dually eligible beneficiaries pose significant challenges to states wishing to coordinate the benefits of the two programs.

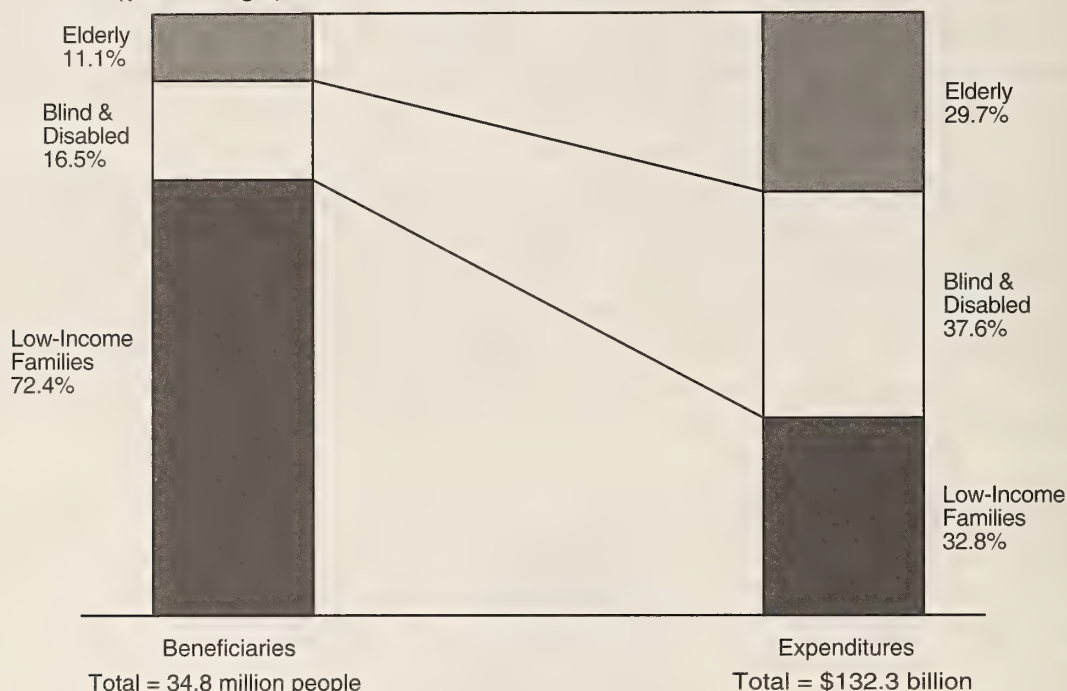
Spending and service use among these various populations are quite different, with Medicaid monies disproportionately spent on disabled and aged beneficiaries. In 1995, average per capita spending for low-income children was roughly \$1,500, while average per capita spending on disabled and elderly beneficiaries was \$8,700 and \$10,100, respectively (Kaiser Commission 1997). Thus, even though children and low-income adults represent nearly three-quarters of Medicaid beneficiaries, total spending for these groups is only slightly more than spending on the elderly, who constitute only 11 percent of the Medicaid population (Figure 1-6). A major share of Medicaid spending on the elderly goes towards long-term care.

In response to recent cost pressures, many states are restructuring their Medicaid programs by expanding their use of managed care. A total of 42 states have waivers of certain federal Medicaid rules, which allow them to require beneficiaries to enroll in managed-care plans. Most states have focused their Medicaid managed-care programs on low-income children and adults. Blind, aged, and disabled beneficiaries remain largely outside of these new managed-care systems. While Medicaid's use of managed-care plans has expanded rapidly, only 5 percent of Medicaid dollars are spent on managed care and 27 percent of the Medicaid population has been enrolled in managed-care plans.

## **NATIONAL HEALTH EXPENDITURE TRENDS**

From 1988 to 1992, national health care expenditures increased at double-digit rates. At the same time, the number of uninsured was growing. These trends fueled efforts in 1993-1994 to reform the health system (Levit et al. 1996a). While broader system reform did not pass in 1994, growth in aggregate health expenditures moderated somewhat in 1993 and 1994, lessening the pressure for systemwide reform. Although policymakers have addressed incremental reforms to address specific issues (such as portability of private health insurance) in the private sector, their attention is now largely focused on Medicare and Medicaid reforms.

**Figure 1-6. Medicaid Beneficiaries and Expenditures by Enrollment Group, 1995**  
(percentage)



SOURCE: Kaiser Commission 1997.

NOTE: Total expenditures exclude administrative expenses and disproportionate share hospital payments.

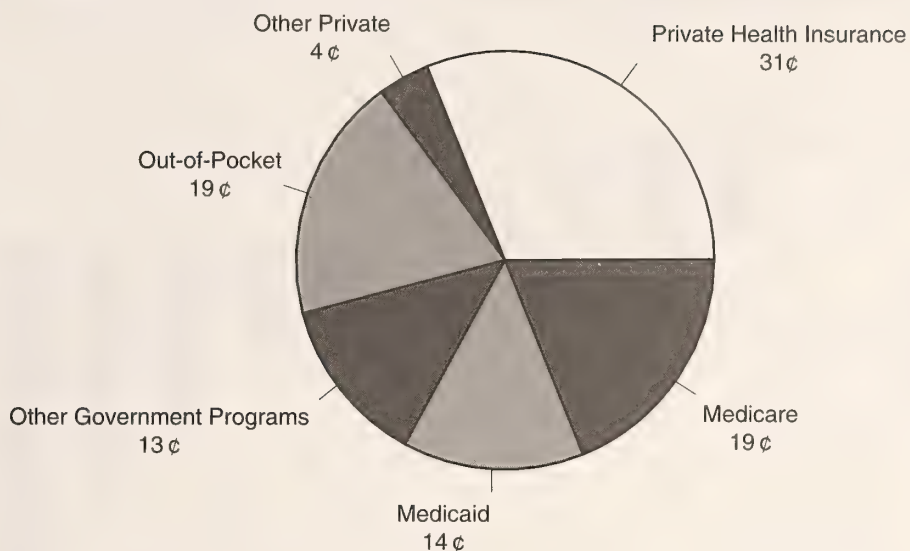
In 1995, national health expenditures accounted for nearly 14 percent of gross domestic product (GDP), reaching \$988.5 billion. The public share of these expenditures was roughly 46 percent, with Medicare accounting for about 19 percent of national health spending and federal and state spending on Medicaid, about 14 percent (Figure 1-7) (Levit et al. 1996b).

### Medicare Expenditure Trends

Medicare's growing share of federal and national health expenditures, as well as its contribution to the federal budget deficit, have made it a primary focus of attempts to constrain federal spending and reach a balanced budget. In 1995, Medicare expenditures reached \$187 billion and accounted for more than 11 percent of federal budgetary outlays, over twice the level of 1975 (Figure 1-8) (CBO 1996; Levit et al. 1996b). Medicare expenditures accounted for roughly 2.6 percent of GDP in 1995 (CBO 1996). The continued growth in spending, together with projections that the Part A trust fund will be exhausted in 2001 in the absence of policy changes, has fueled recent efforts to revamp the program (Figure 1-9) (Board of Trustees 1996).



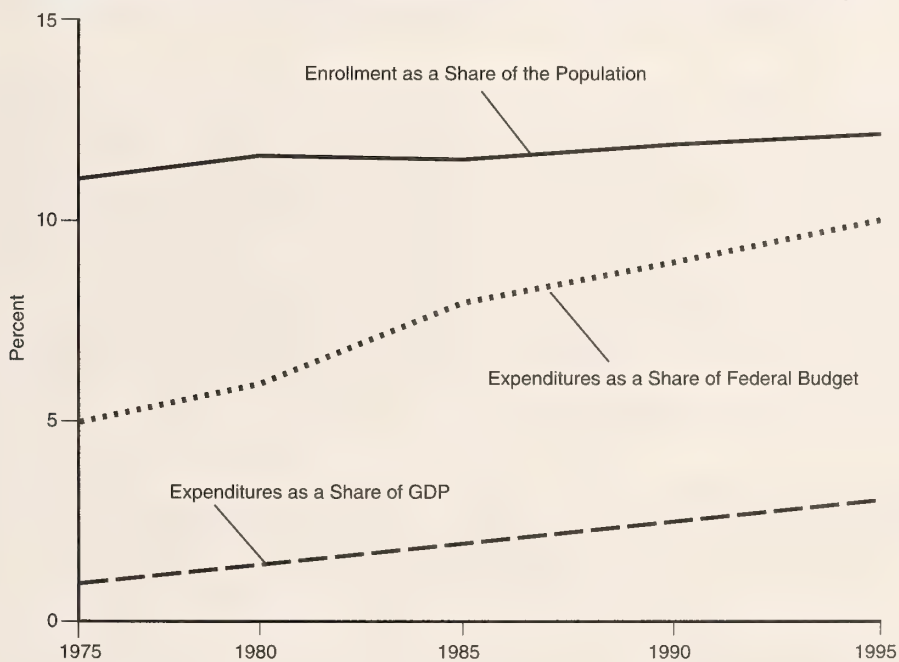
**Figure 1-7. The Nation's Health Dollar, 1995**



SOURCE: Levit et al. 1996b.

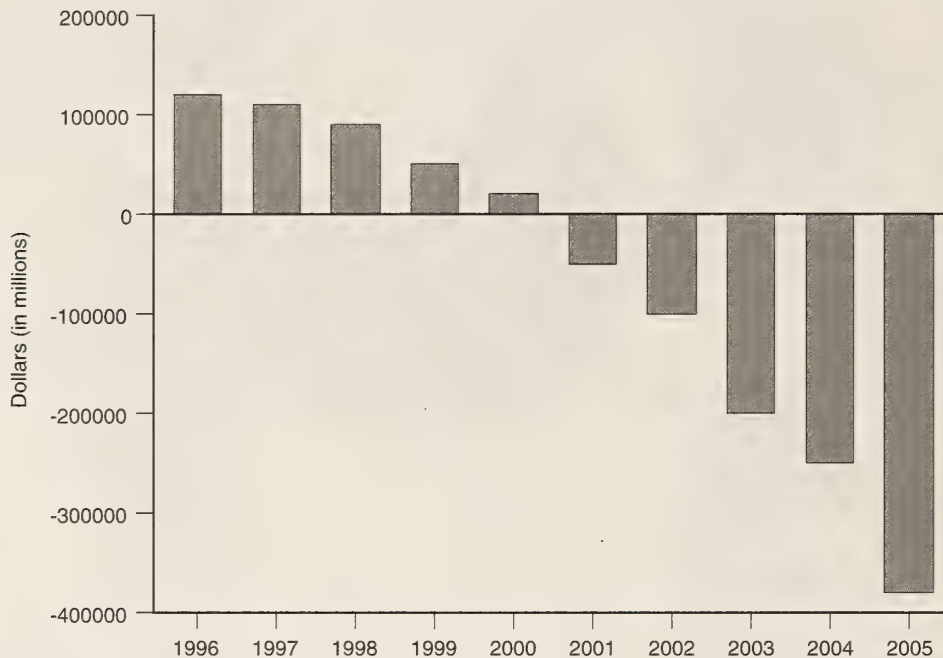
NOTE: "Other Private" includes industrial inplant health services, nonpatient revenues, and privately financed construction.

**Figure 1-8. Medicare Enrollment and Expenditures, 1975-1995 (percentage)**



SOURCE: CBO 1996.

**Figure 1-9. Projected Medicare Hospital Insurance Trust Fund Balance, 1996-2005**  
(millions of dollars)



**SOURCE:** Board of Trustees 1996.

**NOTE:** The Federal Hospital Insurance Trust Fund Board of Trustees prepares three sets of projections each year based on high-cost, low-cost, and intermediate assumptions. These figures are based on intermediate assumptions for the end of each fiscal year.

Growth in Medicare expenditures is a function of increases in the number of beneficiaries and in spending per beneficiary. Per beneficiary spending increases are influenced by inflation (i.e., increasing prices) and changes in the number and mix of services, referred to as volume and intensity.<sup>4</sup> Past efforts to control spending growth have focused primarily on setting the price that Medicare pays for specific services and on controlling increases in those prices. For example, in 1983, Medicare adopted the prospective payment system to pay hospitals a fixed amount per diagnosis, rather than their actual costs. Physician payment reforms enacted in 1989 established the Medicare Fee Schedule for physicians' services that links annual payment updates to growth in the volume and intensity of services provided to beneficiaries two years earlier.

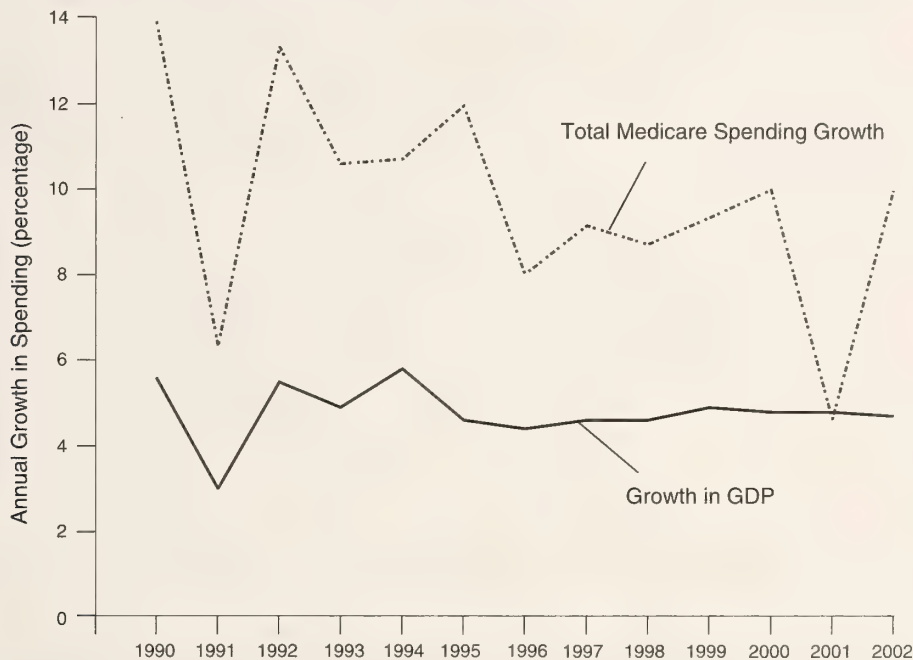
Despite efforts to restrain increases in prices and to influence growth in the volume and intensity of physicians' services, Medicare spending continues to outpace growth in GDP, a trend that is expected to continue in nearly every year through 2002 (Figure 1-10). Between 1985 and 1995, total Medicare

---

<sup>4</sup> Changes in volume and intensity can result from changes in patterns of care, technology, and the health status of the population.

expenditures rose by 9.9 percent annually, with average Part A costs rising 9.4 percent per year and those for Part B growing at close to 11 percent per year (Figure 1-11).

**Figure 1-10. Actual and Projected Growth in Gross Domestic Product (GDP) and Total Medicare Spending, 1990-2002 (percentage)**

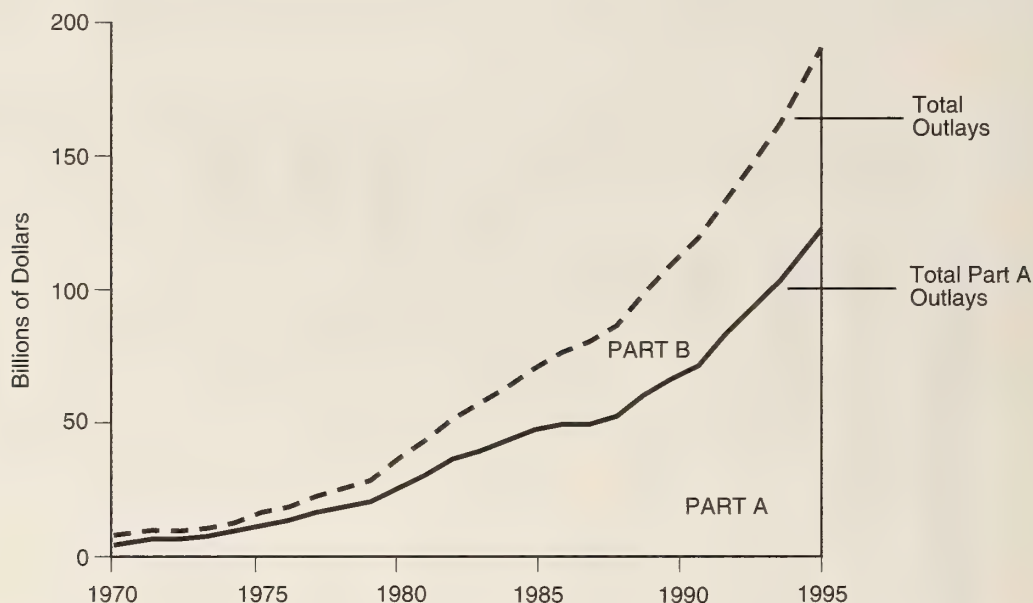


SOURCE: CBO 1997.

Among spending categories, however, growth rates differ markedly. Reforms in hospital and physician payment methodologies have moderated growth in these two major categories somewhat. Since 1991, annual Medicare hospital spending has increased at an average of 9.2 percent, while that for physicians' services has risen 6.0 percent, on average. By contrast, spending in other categories has grown more dramatically. For example, since 1985 outpatient, Part B home health, and laboratory care expenditures have all increased by more than 13 percent annually (Table 1-1). Annual spending for skilled nursing facility care has grown, on average, about 33 percent, while Part A home health care costs have increased by roughly 23 percent, making these areas the focus of many recent proposals to reform Medicare.



**Figure 1-11. Total Medicare Expenditures, 1970-1995 (billions of dollars)**



**SOURCE:** Physician Payment Review Commission analysis of data from Health Care Financing Administration, Office of the Actuary.

**NOTE:** Does not include administrative or peer review organization expenses.

**Table 1-1. Medicare Expenditures and Average Annual Rates of Growth, by Service Category, Selected Calendar Years, 1985-1995**

	Expenditures (in millions of dollars)			Average Annual Rates of Growth	
	1985	1990	1995	1985-1995	1991-1995
<b>Part A</b>					
Inpatient	\$44,940	\$59,451	\$89,130	7.1%	9.2%
Skilled Nursing Facility	548	2,575	9,541	33.1	37.7
Home Health Care	1,913	3,686	15,503	23.3	30.6
Hospice	43	358	2,002	46.8	37.4
<b>Part B</b>					
Physician	17,312	29,609	40,457	8.9	6.0
Outpatient	4,319	8,482	15,405	13.6	12.0
Home Health Care	38	74	182	17.0	29.4
Laboratory Services	558	1,476	2,046	13.9	5.8

**SOURCE:** Physician Payment Review Commission analysis of data from Health Care Financing Administration, Office of the Actuary.

## Spending Growth in Medicare and the Private Sector

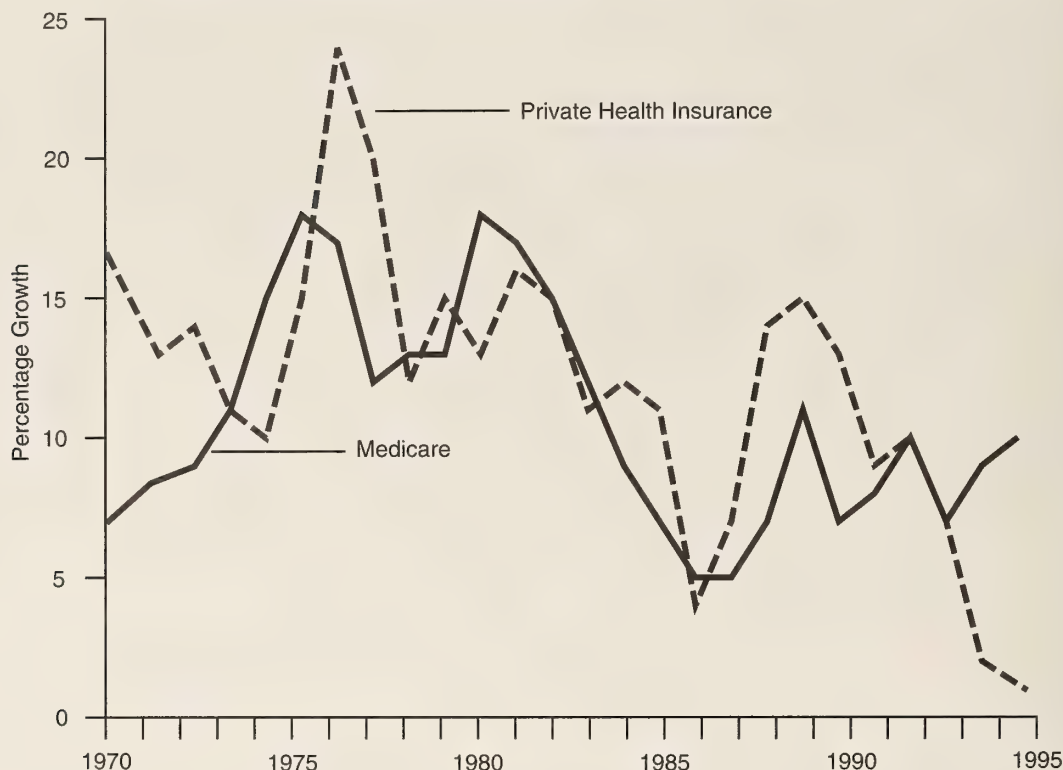
Recent comparisons of Medicare and private insurance expenditure growth have been cited as evidence that Medicare should adopt private-sector management techniques to reduce costs. For example, much has been made of the fact that per enrollee Medicare spending grew 9.8 percent in 1994, while private health insurance spending rose only 4.1 percent (Levit et al. 1996a). Although there are many reasons to introduce some private-sector innovations into Medicare—among them greater provider and plan accountability, more predictable costs, increased beneficiary choice, and improved coordination of care—policymakers must be cautious in comparing spending growth in the two sectors and then basing policy decisions on those comparisons. Differences in enrollment, covered services, and Medicare payment policies may account for much of the reported discrepancy in spending between the two groups.<sup>5</sup> Moreover, per capita spending trends in both Medicare and the private health insurance market have been quite volatile in the past. Adjusting for differences in enrollment growth, covered services, and 1994 Medicare Fee Schedule updates for physician services reduces the discrepancy in 1994 spending rates to 2 percent (Levit et al. 1996a). Furthermore, for 16 of the past 26 years, per enrollee spending growth in Medicare has been lower than that of private health insurance. Rarely has either Medicare or private health insurance had lower per capita spending growth for more than two to four years (Figure 1-12).

Perceptions that recent declines in average premiums for employer-provided health insurance are related to employers' increasing use of managed-care plans have created expectations that increasing managed-care enrollment in Medicare will help curb program spending. These expectations, however, may not be borne out. It is still unclear, for example, whether private-sector spending has permanently slowed. Over short periods, health spending is quite volatile, and costs for employer-based insurance are expected to rise more steeply in the near future (Foster Higgins 1997). In addition, employers may have benefited already from the one-time savings that a switch from indemnity insurance to managed-care plans can produce (Moon and Zuckerman 1995; Foster Higgins 1997). Furthermore, annual premium levels are not necessarily indicative of the real costs of covering health benefits. Because of the underwriting cycle, premiums may show little or no increases for a few years but grow rapidly thereafter (Ginsburg and Pickreign 1996; Gabel et al. 1991; Jensen et al. 1997). Finally, because of flaws in Medicare's payment methodology for managed-care plans, Medicare may be overpaying health plans for some enrollees. As a result, under current policy, moving more Medicare beneficiaries into managed-care plans would not necessarily reduce overall Medicare expenditures.

---

<sup>5</sup> Comparing growth rates in Medicare and private insurance requires accounting for changes in the number of people covered by each type of insurance, removing spending for services not covered by both Medicare and private insurance, accounting for changes in benefits from one year to the next, and discounting the effect of Medicare's payment updates to physicians (Levit et al. 1996a). This last element reflects the fact that annual Medicare payment updates to physicians rely, in part, on physicians' success in controlling volume and intensity growth two years earlier, so that physician spending in 1994 reflects updates that were based on 1992 physician performance.

**Figure 1-12. Growth in Expenditures per Enrollee for Medicare and Private Health Insurance, 1970-1995 (percentage)**



SOURCE: Levit et al. 1996b.

NOTE: Expenditures include benefits and administration for Medicare and benefits and net cost of insurance for private health insurance.

There are other important differences between Medicare benefits and beneficiaries and employer-sponsored plans and their enrollees. Medicare beneficiaries are older and tend to be less healthy than the insured working population. Private health insurance tends to cover prescription drugs and other services not covered by Medicare. Most importantly, employers have greater flexibility than Medicare to reduce benefits and increase beneficiary cost sharing as a means of constraining spending growth (Davis and Burner 1995; Moon and Zuckerman 1995).

As Medicare is challenged to improve program performance, it must do so in ways that are compatible with its role as a public program. It must seek innovative responses to the changing marketplace while operating within both political and fiscal constraints.

### Medicaid Expenditure Growth

In 1995, the growth rate in Medicaid expenditures was about 9 percent, and state and federal Medicaid spending accounted for nearly 14 percent of total national health expenditures (Levit et al. 1996b).



This growth rate was significantly lower than when it reached extremely high levels in the late 1980s due to high rates of general inflation, significant enrollment expansions, and new financing practices. Between 1988 and 1992, Medicaid expenditures increased at an average rate of 22.4 percent per year (Holahan and Liska 1997). Since then, however, Medicaid expenditure growth has moderated. Between 1992 and 1995, Medicaid spending grew only 9.5 percent annually. Although Medicaid is still expected to grow more quickly than the overall economy, future projections put average annual increases at 7.7 percent until 2002, due in part to lower expected growth in enrollment (CBO 1997).

## **THE CHANGING MARKET FOR HEALTH SERVICES**

Managed care is growing and changing rapidly. Distinctions among the roles and structures of health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) plans, and other types of managed-care plans have become increasingly blurred. Conventional insurers have created preferred provider networks and other, more tightly managed health plans. Some PPOs are beginning to accept financial risk and are defining new roles and responsibilities for primary care physicians. A few staff-model HMOs are spinning off their affiliated provider groups while other groups of providers are joining to form provider-sponsored organizations (PSOs) that compete for commercial business. Some provider groups are contracting directly with purchasers, avoiding intermediate management structures and organizations entirely.

These shifts in managed care raise a number of policy issues. Policymakers must consider how these new entities should be defined and regulated, and describe the appropriate roles for the states and the federal government. For example, recent debates about PSOs have centered on issues of plan solvency requirements and consumer protection in the event of individual plan failures.

Much of the recent impetus for change in the American health system has come from employers. Concern about rising health costs, including growing expenditures for retirees and the need to make these costs more predictable, has led many employers to be more aggressive purchasers of health insurance. Some employers have taken steps on their own while others are forming business coalitions to purchase health care.

Large purchasers are using a range of strategies to reduce premiums and improve the value and quality of the products they offer to employees. Among these are providing incentives to employees and retirees to select managed-care options; negotiating for lower increases or reductions in premiums; introducing competitive bidding for plan contracts; setting standards for quality, access, and performance; and contracting directly with providers. These large purchasers are also demanding greater accountability from the providers and plans with which they do business. This trend is evident in many purchasers' increased attention to measuring their employees' attitudes about their health care. Leading-edge purchasers are using accreditation standards, quality reviews, and performance reports to select health plans with which to contract and to assess the quality of those and other health

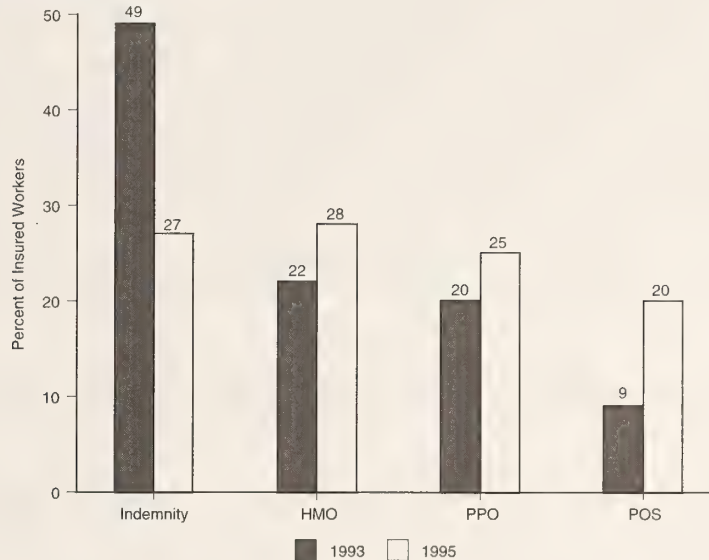
plans on a continuing basis. A few are using incentives and information on plans' quality and performance to steer enrollees into specific plans.

An outgrowth of these trends has been a greater array of health care options from which employers—and consequently many employees—are able to choose. In 1995, most insured workers had a choice of employer-sponsored health plans: 62 percent could select from two or more health plans, although the number of choices depended largely on the size of the employer. Only 10 percent of employees of firms with fewer than 50 workers had a choice of health plans in 1995 (Jensen et al. 1997). About half of midsize employers—those with 200 to 999 workers—offer two or more health plans, while well over 70 percent of companies with more than 1,000 workers offer such a choice (KPMG Peat Marwick 1996).

Some private employers have adopted a system under which they provide a defined contribution toward the cost of health insurance to each employee. The amount of the contribution may be equal for all employees or related to the cost of one or more of the available health plans. The employee is given a range of health plans from which to select coverage, and the employer's contribution is applied to that plan's premium. If an employee elects to enroll in a plan with a premium that exceeds the employer contribution, the employee must pay the difference. If, however, the employee selects a plan that costs less than the employer's contribution, the employee pays nothing. This model is intended to encourage plans to compete on the basis of premium cost and plan characteristics and consumers to be cost-conscious. In 1995, one-third of employees who had a choice of health plans faced a defined contribution from their employer (Jensen et al. 1997). Two public-sector purchasers—the Federal Employees Health Benefits Program and the California Public Employees' Retirement System—have adopted defined-contribution systems and are often considered to be models for this approach.

In 1995, nearly three-quarters of workers with employer-provided health insurance received their care through an HMO, PPO, or POS plan, an increase of 22 percent since 1993 (Jensen et al. 1997). This growth in the proportion of employees covered by managed-care plans may, in part, reflect the decline in the number of employers that offer the option of an indemnity plan. In 1996, for example, only 57 percent of firms with more than 200 employees offered their workers an indemnity plan option. POS plans have shown the largest enrollment increases in the last two years (Figure 1-13).

**Figure 1-13. Insured Workers Covered by Different Types of Plans, 1993 and 1995 (percentage)**



SOURCE: Jensen et al. 1997.

NOTE: HMO is health maintenance organization; PPO is preferred provider organization; POS is point-of-service plan.

Managed-care enrollment among Medicare and Medicaid beneficiaries is also growing, as are the types of managed-care plans offered by these programs. By mid-1996, for example, nearly two-thirds of Medicare beneficiaries lived in a ZIP code that was serviced by at least one Medicare risk plan; 11 percent were enrolled in such plans.<sup>6</sup> Medicare's managed-care program has been dominated historically by HMOs. Recently, however, the Health Care Financing Administration has begun expanding the range of plan options available to Medicare beneficiaries and experimenting with alternative payment mechanisms and methods to adjust payments for the relative health risks of plan enrollees. Beneficiaries in some areas are now able to select PSO, PPO, and POS plan options, although in some cases, only on a demonstration basis. State Medicaid programs have had more experience with managed care and are using both HMOs and primary care case management to deliver health services to their beneficiaries.

Enrollment rates in managed-care plans among Medicare and Medicaid beneficiaries are still below those in the private sector. Although 28 percent of workers with employer-provided health insurance received their care from an HMO in 1995, only 11 percent of the Medicare population and 27 percent of Medicaid beneficiaries were enrolled in similar managed-care plans (Figure 1-14).<sup>7</sup> Medicare managed-care enrollment has been growing at between 25 percent and 35 percent over the last several

<sup>6</sup> For an in-depth discussion of Medicare risk plan availability and enrollment, see Chapter 2.

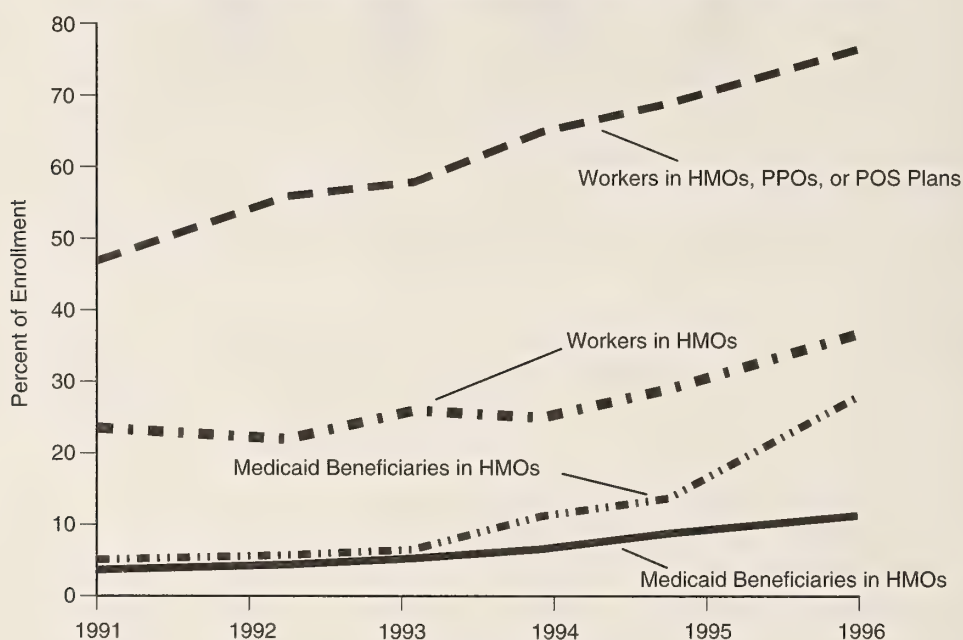
<sup>7</sup> For more information about Medicaid programs' increasing use of managed-care plans, see Chapter 20.



years, and this trend is expected to continue. Expanded opportunities to enroll in PPOs and POS plans may further encourage beneficiaries to try managed-care plans.

The changing market for health services has created a number of challenges for policymakers seeking to reform Medicare and Medicaid. Among these is the extent to which these public programs can adopt some recent private-sector innovations and take advantage of the opportunities that the changing market presents. This annual report looks at these issues for the fee-for-service and managed-care portions of Medicare, as well as for Medicaid. It also addresses a number of issues that are of equal concern in the public and private sectors because of their effects on access, quality, consumer protection, and the training and availability of health professionals in the future.

**Figure 1-14. Trends in Managed-Care Enrollment, 1991-1996 (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of data from Health Care Financing Administration and KPMG Peat Marwick (1996).

**NOTE:** Enrollment data for workers refers to workers in large firms. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

## REFERENCES

- Board of Trustees, Federal Hospital Insurance Trust Fund, *The 1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC: June 1996).
- Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (Washington, DC: August 1996).
- Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1998-2007* (Washington, DC: January 1997).
- Davis, Margaret H., and Sally T. Burner, "Three Decades of Medicare: What the Numbers Tell Us," *Health Affairs* 14(4):231-243, Winter 1995.
- Foster Higgins, *National Survey of Employer-Sponsored Health Plans, 1996* (New York: 1997).
- Gabel, Jon, Roger Formisano, Barbara Lohr, et al., "Tracing the Cycle of Health Insurance," *Health Affairs* 10(4):49-61, Winter 1991.
- Ginsburg, Paul B., and Jeremy D. Pickreign, "Tracking Health Care Costs," *Health Affairs* 15(3):140-149, Fall 1996.
- Health Care Financing Administration, Department of Health and Human Services, *Profiles of Medicare* (Washington, DC: May 1996).
- Holahan, John, and David Liska, "The Slowdown in Medicaid Spending Growth: Will it Continue?" *Health Affairs* 16(2), March/April 1997, forthcoming.
- Jensen, Gail A., Michael A. Morrissey, Shannon Gaffney, et al., "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs* 16(1):125-136, January/February 1997.
- Kaiser Commission on the Future of Medicaid, *Medicaid Facts: The Medicaid Program at a Glance*, Fact Sheet (Washington, DC: 1997, forthcoming).
- KPMG Peat Marwick, *Health Benefits in 1996* (October 1996).
- Levit, Katharine R., Helen C. Lazenby, Lekha Sivarajan, et al., "National Health Expenditures, 1994," *Health Care Financing Review* 17(3):205-242, Spring 1996a.
- Levit, Katharine R., Helen C. Lazenby, Bradlely R. Braden, et al., "National Health Expenditures, 1995," *Health Care Financing Review* 18(1):175-214, Fall 1996b.

- Moon, Marilyn, *Restructuring Medicare's Cost-Sharing* (New York: Commonwealth Fund, December 1996).
- Moon, Marilyn, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries* (New York: Commonwealth Fund, December 1996).
- Moon, Marilyn, and Stephen Zuckerman, *Are Private Insurers Really Controlling Spending Better Than Medicare?* (Menlo Park, CA: Henry J. Kaiser Family Foundation, July 1995).
- Social Security Administration, *Income of the Population 55 or Older, 1994* (Washington, DC: January 1996).



# Medicare Managed Care: Participation and Payment

Growing numbers of both health plans and beneficiaries have moved into Medicare managed care since the risk-contracting program was created in 1982. Almost two-thirds of all beneficiaries now have the option of selecting private health plans instead of receiving health services through the traditional fee-for-service program. About one in eight beneficiaries obtained Medicare coverage through a managed-care arrangement at the end of 1996.

During the 104th Congress, there was extensive debate over ways to broaden the array of options available to Medicare beneficiaries. That debate continues in the 105th Congress. Although policymakers differ on the urgency of moving beneficiaries away from traditional Medicare and the use of incentives to convince them to switch, expanding beneficiaries' choices is broadly supported.

Last year the Physician Payment Review Commission examined the existing range of options and what others might be made available if Medicare were to mimic private-sector offerings. It also reviewed alternative approaches to setting the standards that private health plans should meet to participate in Medicare, the methods used to pay health plans, and the steps that might be taken to facilitate beneficiaries' ability to make informed choices.

As the number and variety of managed-care offerings grow under current policies, the degree of choice available to beneficiaries varies widely across communities nationwide. Also, the additional benefits offered and the premiums plans charge vary geographically.

*This chapter includes new information on:*

- *Current Medicare managed-care options*
- *Availability of risk plans*
- *Risk-plan enrollment trends*
- *Payments to risk plans*
- *Additional benefits offered and premiums charged by plans*

This chapter describes current policy, including the different types of plans beneficiaries can choose. It presents new data on the availability of risk plans nationwide and examines trends and patterns in beneficiary enrollment in these plans. The chapter outlines briefly the methodologies Medicare uses to pay plans. Finally, it describes plans' additional benefits and premiums, as well as the results of new analysis on market competition around benefits and premiums. Primarily descriptive, the chapter is designed to offer basic information on Medicare managed care under current policies. Several other chapters describe possible ways to modify current law under different visions of how the program should evolve over the next several years.<sup>1</sup>

## **CURRENT POLICY AFFECTING MEDICARE MANAGED CARE**

A private health plan has several different ways to participate in Medicare. First, a plan can enter into a Medicare risk contract, under which it receives capitated payments for the beneficiaries it enrolls. Based on guidelines issued in October 1995, risk contracts may also include a point-of-service (POS) option, which lets beneficiaries use providers outside the plan's network. Second, a plan can enter into a cost contract, under which it is paid on a fee-for-service basis for the reasonable costs of delivering services to its enrollees. Finally, on a demonstration basis, the Health Care Financing Administration (HCFA) allows other arrangements such as social health maintenance organizations, which manage care across a broad spectrum of acute and long-term care services and are jointly financed with Medicaid. HCFA's most recent demonstration project in this area, Medicare Choices, is designed to encourage different types of plans to participate.

### **Medicare Risk Contracts**

Under the risk-contract option, established in its current form in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), health maintenance organizations (HMOs) must offer beneficiaries all Medicare-covered services for a capitated payment. Most risk plans also offer supplemental benefits like coverage for cost sharing or services not otherwise covered by Medicare. Enrollees may be charged a premium (above the Part B premium they pay Medicare) for these services. Nearly two-thirds of all risk plans do not charge more for these services and are referred to as zero-premium plans.

In general, enrollees who select a risk plan must use its network of providers and agree to obtain all covered services through the plan, except in emergencies. If the plan authorizes use of nonnetwork providers, such services are paid by the plan, not by Medicare. Enrollees may terminate enrollment at any time, effective on the first day of the month following the request.

Risk contracts are the fastest-growing and most prevalent form of managed care under Medicare. Most of the discussion of plan participation and beneficiary enrollment later in this chapter focuses on the risk program.

---

<sup>1</sup> In addition, see chapters in the Commission's 1996 annual report on expanding plan options (Chapter 2), standards for plan participation (Chapter 3), and facilitating beneficiary choice (Chapter 4) (PPRC 1996a).

## **Medicare Point-of-Service Option**

Until recently, point-of-service options were generally not available to Medicare beneficiaries. In 1995, HCFA clarified that authorized risk contractors may offer such an option (HCFA 1995b). That action was intended to encourage more beneficiaries to join managed-care plans by expanding their ability to use out-of-network providers or to obtain care when traveling outside their plan's service area. By January 1997, about 30 risk plans were offering POS as an optional benefit.

Most of the decisions about the structure of the POS benefit are left to the plans. They can determine which services will be covered on a point-of-service basis, use precertification to approve out-of-plan services, and set annual dollar limits on the amount of such services for which beneficiaries will be covered. Plans must still offer all Medicare-covered services within the plan, and HCFA must approve the coinsurance rates and deductibles for out-of-plan services.

Among the plans already offering the POS option, the rules governing its use vary substantially. Most plans limit the amount of out-of-network benefits that can be covered; annual limits range from \$1,500 to \$50,000 or more. Most also charge 20 percent coinsurance for POS coverage and impose an annual deductible of anywhere from \$100 to \$1,000 for it. Premiums for this optional benefit are generally \$15 to \$60 per month. There are no estimates on how many beneficiaries have selected this option or on utilization of services on a POS basis.<sup>2</sup>

## **Cost-Based Contracts**

Two different types of cost-based contracts exist in Medicare. Health care prepayment plans (HCPPs) were authorized by the original Medicare statute and apply only to Part B services. A second type of cost contract (sometimes called a TEFRA cost contract) covers all Medicare services. It was first authorized in 1972, with rules modified under TEFRA in 1982. Under both options, beneficiaries enroll with a plan and may pay a premium to obtain supplemental benefits, such as a waiver of cost-sharing requirements.

Under either type of cost contract, the plan receives an interim payment based on its own cost estimates; final payments for services rendered are determined by comparing the amount of interim payments with actual allowable costs for services delivered. Medicare pays the plan for the services of network providers, subject to a test of reasonableness.

In contrast to those enrolled in risk contracts, enrollees in cost-contracting plans have an unrestricted option to go out of network. Medicare pays nonnetwork providers delivering services to cost-contract enrollees using normal Medicare policies. Those who purchase coverage of cost sharing from the plan as a supplemental benefit have a financial incentive to stay in the network because the plan will pay these costs.

---

<sup>2</sup> Although there is no estimate of how many people have selected the POS option, about 500,000 beneficiaries—a little over 10 percent of all risk-plan enrollees—are enrolled in the 30 plans that offer the POS option.



## **Medicare Choices Demonstration Project**

The Medicare Choices demonstration project was designed to offer flexibility in contracting requirements and payment methods for health plans and other organized delivery systems that wish to participate in Medicare. Its broader purpose is to test beneficiaries' responses to a range of health care delivery system options and to evaluate their suitability for Medicare. In June 1996, HCFA selected 25 plans for possible participation in the demonstration. These plans were concentrated in seven urban markets and rural areas in several states. Six of the plans have since withdrawn from participation for a variety of reasons.

Six of the plans (located in Houston, Orlando, Philadelphia, and rural Virginia) were permitted to start enrolling beneficiaries as of January 1, 1997. (The Virginia plan has dropped out and will operate under a traditional risk contract.) One plan in Montana and two in Ohio were authorized to start on March 1. These eight plans include seven provider-sponsored organizations (PSOs) and one preferred provider organization (PPO). Other plans are likely to begin operation later in 1997 (HCFA 1996a; HCFA 1997). Early reports suggest that one, the Florida Hospital Healthcare System, was actively enrolling beneficiaries and had more than 1,000 members after just two months. The other plans were still in early marketing stages as of early March.

Two of the plans are the first to participate in Medicare without a state HMO license. Health Plans of Philadelphia, developed by the Crozer-Keystone Health System, is licensed by the state as a risk-bearing PPO. The plan's license allows it to accept a capitation payment, but it is prohibited from capitating its contracted providers. Instead, it must use normal fee-for-service payment rules, such as the Medicare Fee Schedule. The plan is reportedly seeking an HMO license to increase its options. The Florida Hospital Healthcare System, which has no commercial (non-Medicare) business, has a letter of understanding from the state insurance department giving it permission to operate without a license. The letter is based in part on the plan's agreement to honor certain consumer protection provisions (Carbine 1997).

## **AVAILABILITY OF MEDICARE RISK PLANS**

In the 1980s, many large HMOs did not participate as Medicare risk contractors. Others stayed in the program only briefly. In the past five years, though, that picture has changed. This section presents some data on the growing numbers of plans participating in Medicare and their availability nationwide.<sup>3</sup>

### **Participation of Health Plans in the Program**

The number of health plans signing risk contracts with the Medicare program reached 241 in 1996, more than double the level three years earlier (Figure 2-1). Plan participation declined from 1987 to

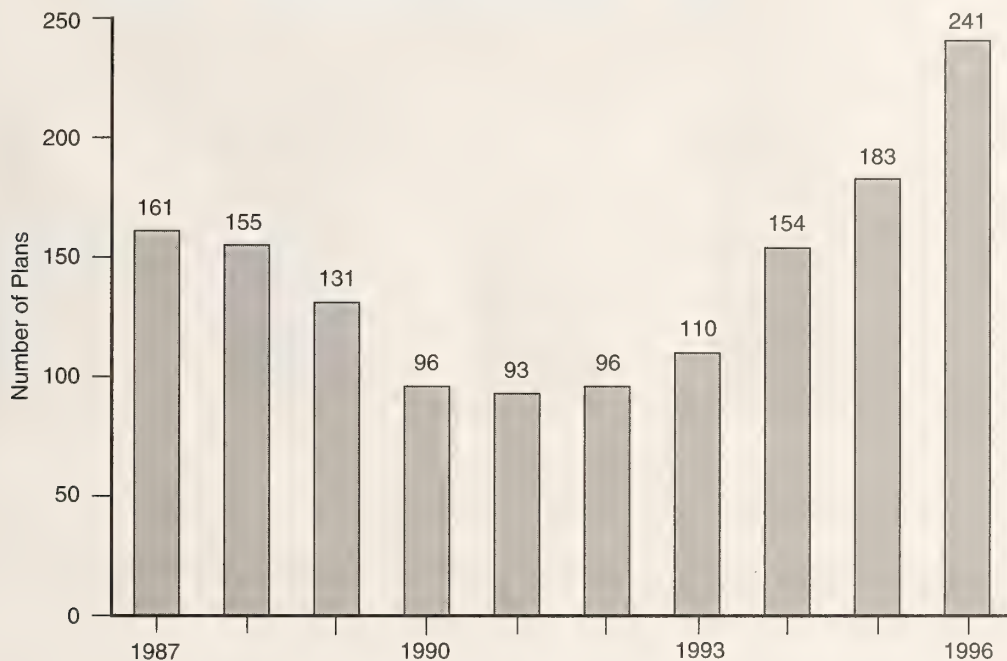
---

<sup>3</sup> Additional data and graphs on plan participation in Medicare are presented in the Commission's publication, *Medicare Risk Plan Participation and Enrollment: A Chart Book* (PPRC 1996b).

the early 1990s. Some plans found that they were losing money on Medicare beneficiaries, perhaps because they got into the program before they were fully ready. Participation began increasing rapidly in 1993 as plans saw Medicare as an attractive market. The trend shows no signs of abating; as of December 1996, another 69 risk-plan applications were pending with HCFA.

In addition to the risk plans, 36 cost plans and 50 HCPPs had contracts with Medicare in December 1996. These numbers have remained relatively constant over the past several years, although some plans have switched between different types of contracts.

**Figure 2-1. Risk Plans Participating in Medicare, 1987-1996**



SOURCE: HCFA 1996b; HCFA 1996c.

NOTE: All data are for December.

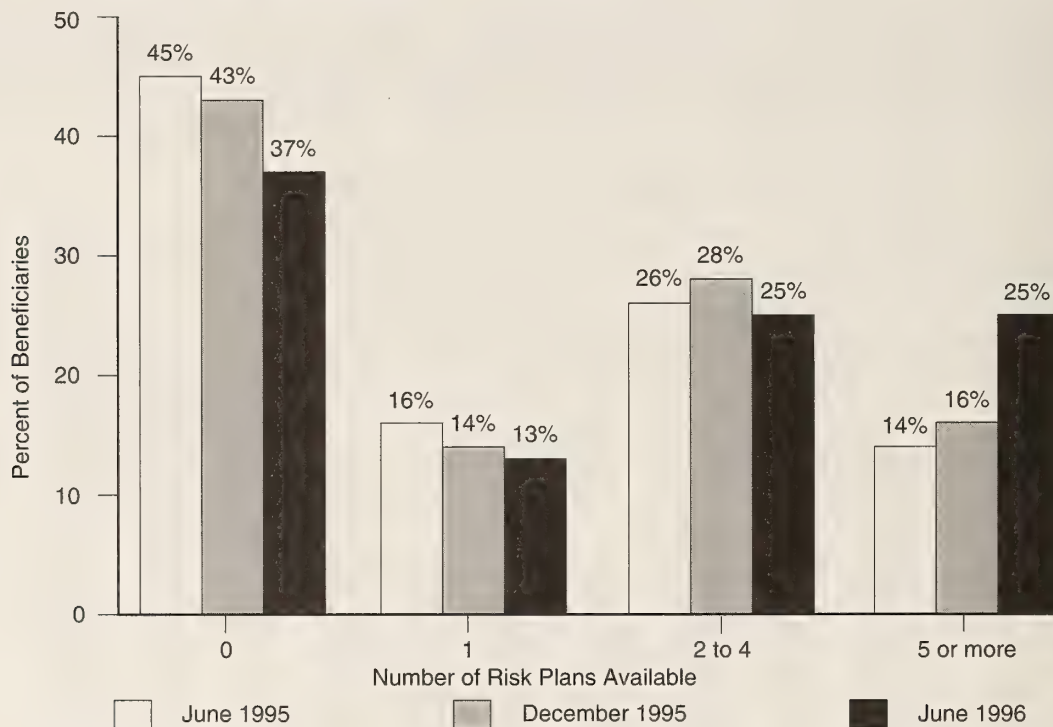
### **Availability of Plans by State and by Urban and Rural Locations**

Although more than 200 plans participate in Medicare's risk program, some beneficiaries have no plan available to them. Under Medicare's rules, each plan serves a specific geographic area. Plans define their service areas as a set of contiguous counties and partial counties, where partial county service areas are designated at the ZIP code level. Typically, a plan serves some portion of a single state or a multistate metropolitan area. Beneficiaries may enroll only in a plan designated as serving their ZIP code of residence.

In June 1996, 63 percent of all Medicare beneficiaries lived in the service area of at least one risk plan (Figure 2-2). About half of all beneficiaries had a choice of plans, and one-fourth had five or more available to them. Over the year from June 1995 to June 1996, 8 percent of all beneficiaries gained

access to at least one risk plan, while the number with access to at least five plans rose from 14 percent to 25 percent.<sup>4</sup>

**Figure 2-2. Distribution of Medicare Beneficiaries, by Number of Risk Plans Available in Their Area, 1995-1996**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

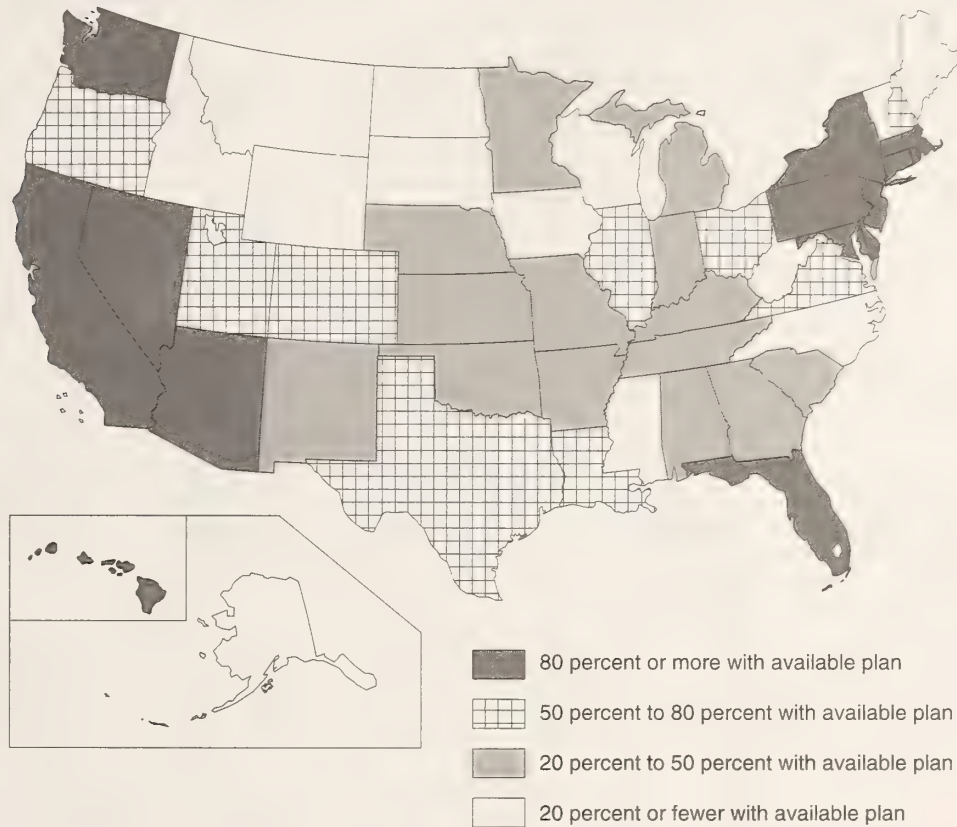
**NOTE:** Area is defined as the ZIP codes in a risk plan's service area.

Plan availability, however, is not uniform across the country. At least half of the beneficiaries in 27 states have no plan available (Figure 2-3). In nine of these states, there are no risk plans. By contrast, in 14 states 80 percent or more of the beneficiaries have access to at least one plan. Moreover, everyone in Connecticut, Delaware, Maryland, and New Jersey has at least one plan they can join.

<sup>4</sup> The Commission's estimate that 63 percent of beneficiaries had access to a Medicare risk plan differs from other published estimates. HCFA estimates that in 1994, 74 percent of beneficiaries lived in areas served by a plan, and 56 percent of beneficiaries had two or more plans available to them (HCFA 1996d). The Prospective Payment Assessment Commission (ProPAC), by contrast, estimates that only 47 percent of beneficiaries lived in a county with a risk plan available in May 1994 (ProPAC 1996). These numbers differ for three reasons: the date of the estimates, the types of health plans considered, and the geographic unit used. First, because the number of plans has grown, 1994 levels should be lower than those in 1995 or 1996. Second, HCFA considered all types of managed-care plans, not just risk plans. Many areas not served by risk plans do have cost plans or HCPPs available. Including these plans would increase the Commission's estimate to 69 percent of beneficiaries in June 1995 and to 77 percent in June 1996, comparable to HCFA's estimate. Third, both HCFA and ProPAC estimates measure availability at the county level, whereas the Commission only counts plan availability when a beneficiary's ZIP code of residence is in a plan's service area. As noted later in the chapter, it is common for plans to serve portions of counties. About one-third of plans have partial counties in their service areas.



**Figure 2-3. Percent of State Medicare Population with at Least One Risk Plan Available, June 1996**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

Where plans are available, the amount of choice varies (Table 2-1). Among the 23 states where at least half the beneficiaries have access to a plan, the typical beneficiary may have considerable choice, for example, 6 plans in New Jersey and 10 or more in California. But even in California, there is no risk plan available to 5 percent of beneficiaries. In states where a smaller share of beneficiaries has access to a plan, multiple options may still be offered. In both Minnesota and New Mexico, for instance, 48 percent of beneficiaries have at least one plan and typically three (Minnesota) or four (New Mexico).

In general, plan availability is much greater in urban areas than in rural ones (Figure 2-4). All residents of central urban areas have at least one choice, while over half have five or more.<sup>5</sup> By contrast, rural beneficiaries rarely have even a single plan available.

<sup>5</sup> In the tables and figures in this chapter, central urban counties are defined as the central counties in metropolitan areas of 1 million population or more; other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those nonmetropolitan counties that are adjacent to a metropolitan area, while other rural refers to nonmetropolitan counties not adjacent to a metropolitan area.

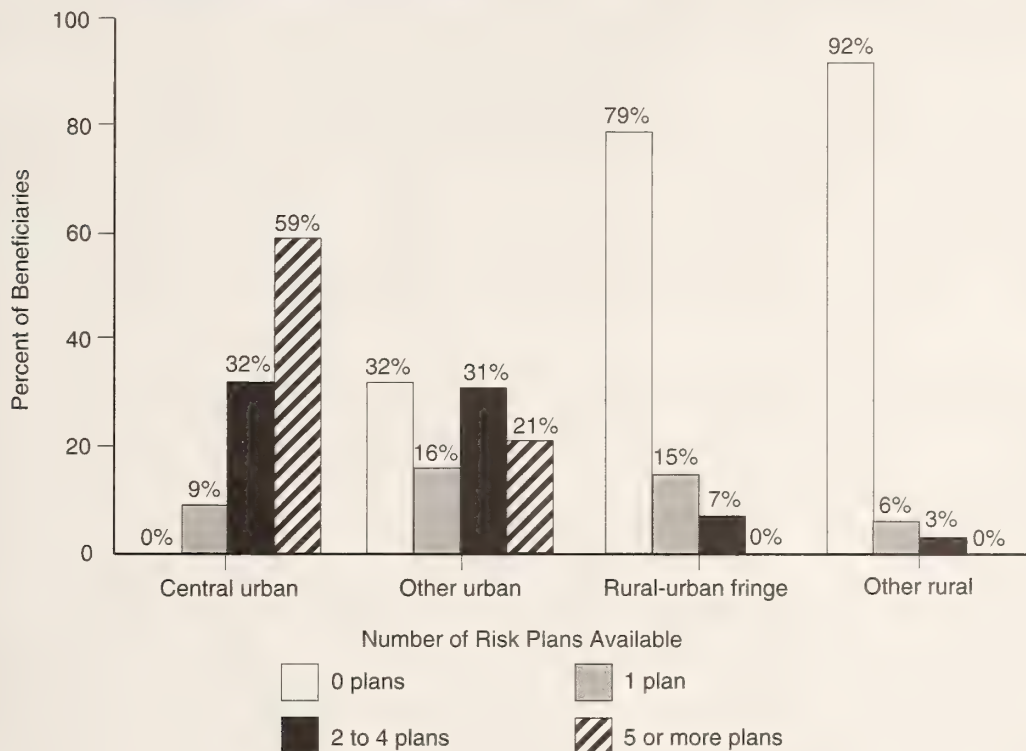
**Table 2-1. Availability of Medicare Risk Plans and Enrollment, by State, June 1996**  
(percentage of beneficiaries)

State	Number of Plans Available				Enrollment
	0	1	2 to 4	5 or More	
United States	37%	13%	25%	25%	10%
Alabama	73	10	17	0	3
Alaska	100	0	0	0	0
Arizona	14	4	7	75	32
Arkansas	80	20	0	0	1
California	5	4	15	76	33
Colorado	26	23	10	41	20
Connecticut	0	0	100	0	2
Delaware	0	0	100	0	4
District of Columbia	0	0	100	0	5
Florida	12	16	17	55	19
Georgia	68	32	0	0	0
Hawaii	18	82	0	0	9
Idaho	100	0	0	0	0
Illinois	39	8	11	42	6
Indiana	73	27	0	0	1
Iowa	97	3	0	0	0
Kansas	68	15	18	0	2
Kentucky	75	25	0	0	1
Louisiana	50	2	48	0	7
Maine	100	0	0	0	0
Maryland	0	0	22	78	4
Massachusetts	3	3	27	67	12
Michigan	53	47	0	0	1
Minnesota	52	6	42	0	9
Mississippi	100	0	0	0	0
Missouri	51	1	48	0	6
Montana	100	0	0	0	0
Nebraska	77	23	0	0	1
Nevada	12	6	83	0	26
New Hampshire	36	42	23	0	1
New Jersey	0	0	2	98	6
New Mexico	52	1	47	0	16
New York	18	11	41	31	8
North Carolina	96	4	0	0	0
North Dakota	100	0	0	0	0
Ohio	29	22	34	15	3
Oklahoma	58	5	37	0	4
Oregon	21	4	74	0	24
Pennsylvania	16	6	78	0	12
Rhode Island	5	17	78	0	9
South Carolina	50	50	0	0	0
South Dakota	100	0	0	0	0
Tennessee	77	23	0	0	0
Texas	35	15	27	23	9
Utah	39	61	0	0	1
Vermont	100	0	0	0	0
Virginia	40	10	49	0	2
Washington	13	12	67	8	18
West Virginia	93	7	0	0	0
Wisconsin	81	19	0	0	0
Wyoming	100	0	0	0	0

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

NOTE: A plan is defined as available to a beneficiary if it serves that beneficiary's ZIP code of residence.

**Figure 2-4. Distribution of Medicare Beneficiaries in Urban and Rural Locations, by Number of Available Plans, June 1996**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

**NOTE:** Central urban counties are defined as the central counties in metropolitan areas of 1 million population or more; other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those nonmetropolitan counties that are adjacent to a metropolitan area, and other rural refers to nonmetropolitan counties not adjacent to a metropolitan area.

The rapid growth of plan availability is occurring in both urban and rural locales. For example, the proportion of central urban residents with five or more plans in their areas grew from 39 percent to 59 percent in just one year's time. Similarly, the percentage of rural beneficiaries in urban fringe areas with at least one plan grew from 11 percent to 21 percent in that same year.

### Plan Availability at the Market Level

Although nearly all beneficiaries who live in the largest urban areas have access to at least one plan and usually several plans, residents of some markets have many more options than others. In an analysis of plan availability in the 31 largest primary metropolitan statistical areas (PMSAs), the variation is evident (Table 2-2). In markets as different as Boston; Houston; Los Angeles; and Riverside, California, most beneficiaries have a choice of five or more plans. Elsewhere, though, choices are far more limited. There is just one plan serving most beneficiaries in Atlanta and Detroit, for instance.



**Table 2-2. Availability of Medicare Risk Plans and Enrollment, by Primary Metropolitan Statistical Area, June 1996 (percentage of beneficiaries)**

Primary Metropolitan Statistical Area	Number of Plans Available				Enrollment
	0	1	2 to 4	5 or More	
Atlanta	14%	86%	0%	0%	0%
Baltimore	0	0	12	88	5
Boston	0	2	20	78	12
Chicago	4	4	19	73	10
Cincinnati	5	20	74	0	3
Cleveland	5	7	20	69	9
Dallas	3	16	81	0	8
Denver	0	0	9	91	34
Detroit	7	93	0	0	1
Houston	0	3	1	96	19
Kansas City	10	0	90	0	11
Long Island	0	0	0	100	14
Los Angeles	0	0	0	100	35
Miami	0	0	0	100	35
Minneapolis	3	7	90	0	19
New York	0	0	64	36	10
Newark	0	0	11	89	3
Oakland	0	0	0	100	31
Orange County, CA	0	0	0	100	39
Philadelphia	0	0	78	22	21
Phoenix	0	0	3	97	37
Pittsburgh	0	0	100	0	15
Portland, OR	0	0	99	1	43
Providence	3	11	54	32	9
Riverside, CA	1	0	7	92	51
San Diego	0	0	2	98	46
San Francisco	0	0	14	86	32
Seattle	0	0	100	0	27
St. Louis	4	30	66	0	8
Tampa	0	0	8	92	23
Washington	3	4	50	43	4

**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

**NOTES:** A plan is defined as available to a beneficiary if it serves that beneficiary's ZIP code of residence.

This table includes 31 primary metropolitan statistical areas with populations over 1.5 million.

In smaller markets, the story is different. Nearly half of the 316 PMSAs in the United States have no plans. These include markets as diverse as Gary, Indiana; Laredo, Texas; Madison, Wisconsin; Syracuse, New York; and Tallahassee, Florida.

A plan may designate its service areas for a variety of reasons, but key factors include Medicare's payment rates and the location of the plan's provider network. First, as described below, plans are paid different amounts in the different counties that make up a market. Second, there may not be enough providers in certain parts of the market, especially in one that spreads over large areas. That is

particularly true for staff-model and group-model HMOs that rely on a few central facilities, but other types of HMOs may also find their networks too limited to provide the level of coverage required by Medicare's standards. It is also possible that some plans might keep certain ZIP codes out of their service areas in an effort to attract healthier enrollees.

An analysis of major markets shows how service area definitions vary around the country. In some of the 31 markets in this analysis, all available plans serve all of the counties in the PMSA; in others, the average plan serves as few as one-third of these counties. For example, plans may serve the central city but not the outlying suburbs, or they may serve one portion of the PMSA. At the ZIP code level, the differences can be even greater. To illustrate, two markets—Boston and Chicago—are described in some detail (Tables 2-3 and 2-4).<sup>6</sup>

**Table 2-3. Overlap between Plan Service Areas and Counties in the Boston Primary Metropolitan Statistical Area, June 1996**

County	Percent of PMSA Population	Risk Plan									
		Harvard (MA)	Harvard (NH)	US Healthcare (MA)	US Healthcare (NH)	Tufts	Pilgrim	HMO Blue	Fallon	United New England	No Plan
Middlesex, MA	35	99		100		100	97	100	45		
Essex, MA	19	99		100		100	85	100	22		
Norfolk, MA	17	98		100		100	100	100	9	5	
Suffolk, MA	15	19		100		100	100	100			
Plymouth, MA	10	86		100		100	100	100			
Rockingham, NH	5		59		100						
Entire PMSA	100%	81%	3%	95%	5%	95%	91%	95%	21%	1%	0%

**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

**NOTE:** The value for each county-plan pair indicates the percentage of Medicare beneficiaries who are in the plan's service area. For example, Harvard Community Health Plan (MA) serves 99 percent of Middlesex County, but only 19 percent of Suffolk County and none of Rockingham County. Harvard Community Health Plan (MA) is available to 81 percent of the beneficiaries in the Boston PMSA.

Plans vary in how they designate their service areas. In Boston, most plans serve counties on an all-or-nothing basis, whereas in Chicago, most service areas include only portions of many of the counties. Humana, for example, covers anywhere from 100 percent to 27 percent of the five counties in its service area. These differences may be no more than historical accident, but they are important to understanding how plans serve the markets in which they operate.

<sup>6</sup> Plan service areas for two other markets—southern California and Washington, D.C.—are shown in the Commission's chart book (PPRC 1996b).

Second, state boundaries matter in different ways across markets. The Boston PMSA includes one New Hampshire county, along with its five Massachusetts counties. Two plans (Harvard Community Health Plan and U.S. Healthcare) serve both the New Hampshire county and the Massachusetts counties, but do so under separate risk contracts based in the two states. By contrast, there are other markets (e.g., Washington, D.C.) where plans span multiple states under a single risk contract. State licensing procedures may be the principal reason why plans operate under separate risk contracts in different states.

**Table 2-4. Overlap between Plan Service Areas and Counties in the Chicago Primary Metropolitan Statistical Area, June 1996**

County	Percent of PMSA Population	Risk Plan					
		Humana	Health Direct	Share	NYLCare	FHP	No Plan
Cook	73	100	100	100	100	100	
DuPage	9	100	100	100	100		
Lake	6	65	58	69			8
Will	4	29	45	12			47
Kane	4	27	19	75	100		
McHenry	2		81	91			7
DeKalb	1						100
Grundy	1						100
Kendall	0						100
Entire PMSA	100%	88%	90%	91%	86%	73%	4%

**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

**NOTE:** The value for each plan-county pair indicates the percentage of Medicare beneficiaries in the county who are in the plan's service area. For example, Humana serves 100 percent of Cook and DuPage Counties, but only 65 percent of Lake County and none of McHenry County. Humana is available to 88 percent of the beneficiaries in the entire Chicago PMSA. No plan serves any part of DeKalb, Grundy, or Kendall Counties, while 8 percent of the beneficiaries in Lake County and 47 percent of the beneficiaries in Will County have no plan available.

Finally, the availability of risk plans varies geographically even within a market. Chicago illustrates. All residents of Cook County and one suburban county have at least four managed-care options, whereas those in three outlying counties have no plans from which to choose. In three closer-in suburban counties, plans serve varying proportions of the populations. Some residents of each of these counties have no managed-care options at all.

## ENROLLMENT TRENDS

Historically, a relatively small percentage of Medicare beneficiaries have enrolled in private health plans, but the numbers have risen rapidly in the past several years. This section presents some data on enrollment in the different types of Medicare plans, including the pattern of concentration in a few

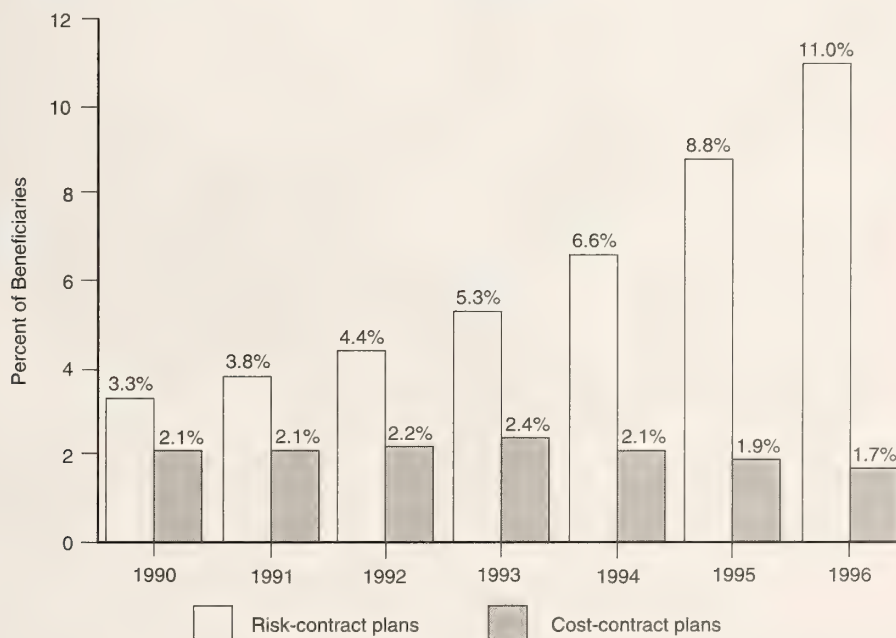


states.<sup>7</sup> Information on the differing characteristics of plan enrollees compared with fee-for-service beneficiaries was presented in last year's annual report (PPRC 1996a). These differences are also central to the discussion of risk adjustment (see Chapter 4).

## National Enrollment

Total enrollment in Medicare risk and cost plans rose to 12.7 percent of all beneficiaries by the end of 1996 (Figure 2-5). The largest numbers and all of the growth have been in risk plans, which increased from 3.3 percent in 1990 to 11.0 percent in 1996; enrollment doubled in just the last three years.<sup>8</sup> The annual rate of growth over the last several years has been in the range of 25 percent to 35 percent. By contrast, enrollment in cost-contracting plans has been generally flat over the decade, with a gradual decline to a low of 1.7 percent in 1996.

**Figure 2-5. Medicare Risk-Plan and Cost-Plan Enrollment, 1990-1996 (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996b; HCFA 1996c).

**NOTE:** All data are for December.

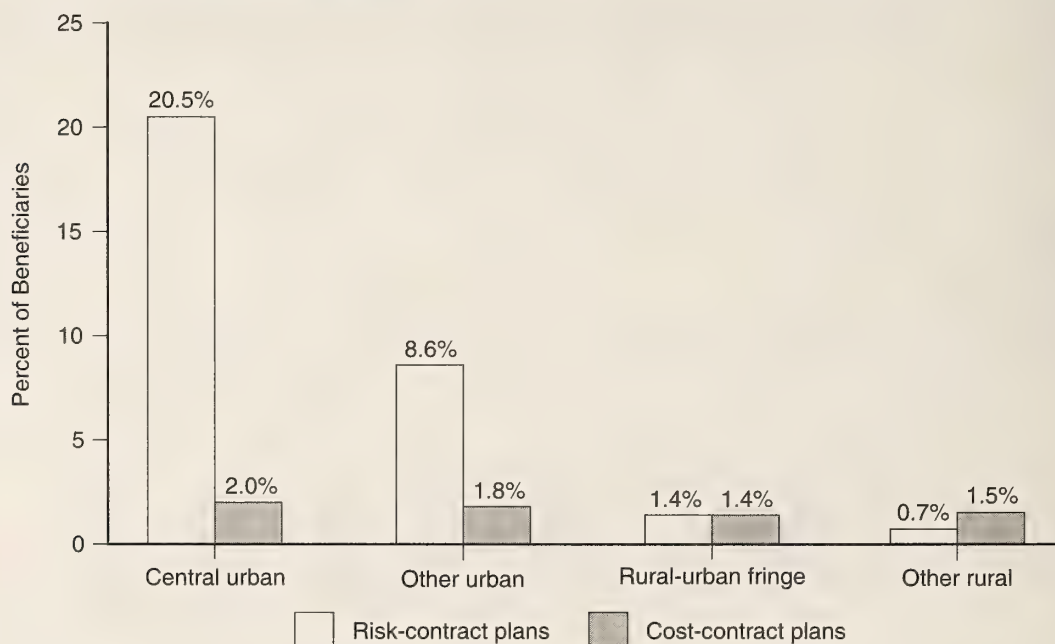
<sup>7</sup> Additional data and graphs on enrollment are in the Commission's chart book (PPRC 1996b). Enrollment can be measured in two ways. One uses HCFA's monthly managed-care reports, where plan enrollments are assigned to the state in which plans are headquartered (HCFA 1996c). The other uses HCFA's individual-level enrollment files, from which state enrollment totals can be calculated. The latter file has some discrepancies, probably because of beneficiaries whose addresses have changed and whose enrollment status was based on a previous address. In addition, total enrollment between the two sources differs by 0.25 percent.

<sup>8</sup> Enrollment further rose from 11.0 percent to 11.9 percent in the three months from December 1, 1996, to March 1, 1997.

Experts agree that this growth will continue, even in the absence of policy changes that might make these plans more attractive. HCFA's actuaries now project that enrollment in risk plans will equal 22 percent by 2005. The Congressional Budget Office expects higher levels, with enrollment projected at 29 percent in 2005. Proposed program changes could push these levels even higher.

Enrollment in Medicare managed care differs substantially across urban and rural locales (Figure 2-6). Risk-plan enrollment in central urban areas (generally, the cities at the core of the largest metropolitan areas) was 21 percent in June 1996, about twice the level in other urban areas. In the most rural areas, however, risk-plan enrollment was less than 1 percent. Enrollment in cost-contract plans was more evenly distributed.

**Figure 2-6. Medicare Risk-Plan and Cost-Plan Enrollment, by Urban and Rural Locations, June 1996 (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment data.

**NOTE:** Central urban counties are defined as the central counties in metropolitan areas of 1 million population or more; other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those nonmetropolitan counties that are adjacent to a metropolitan area, and other rural refers to nonmetropolitan counties not adjacent to a metropolitan area.

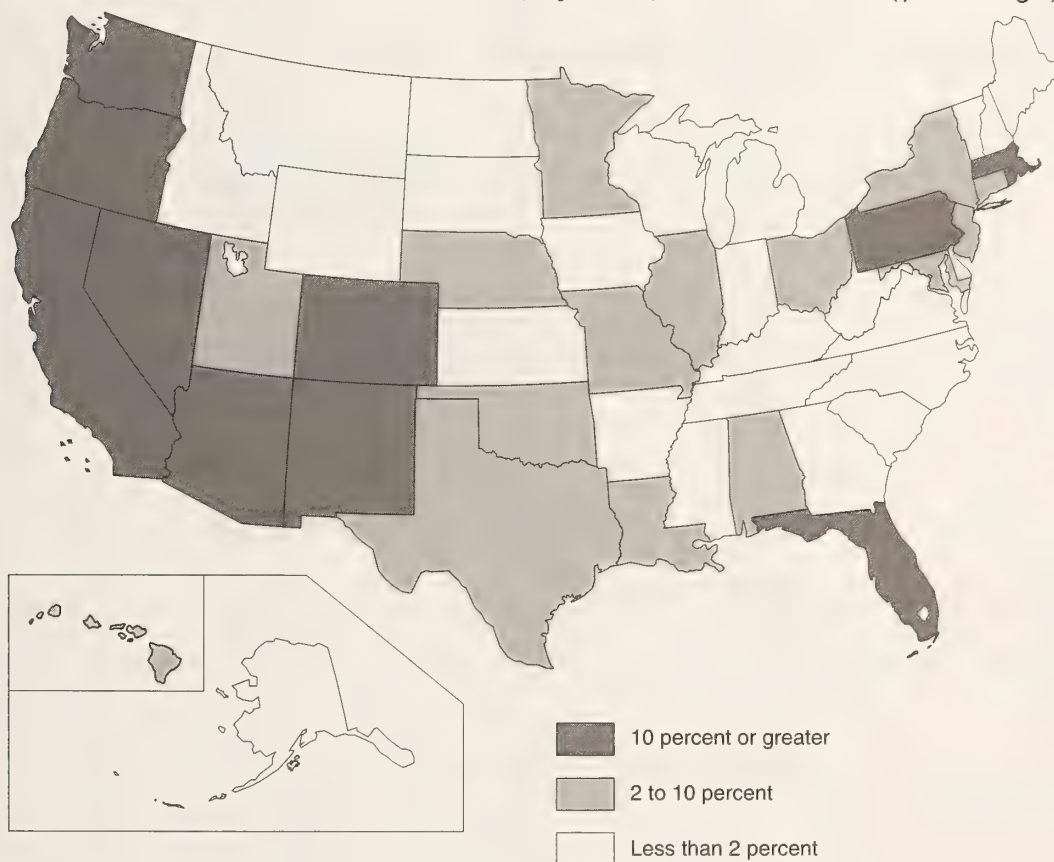
Enrollment is growing in all type of locales, however. In the most urban areas, the share of beneficiaries in risk plans rose from 17 percent to 21 percent in a year's time. In the most rural areas, risk-plan enrollment nearly doubled from 0.4 percent to 0.7 percent.

## Enrollment Patterns among the States

Enrollment patterns are not uniform around the country, with substantially higher enrollment in a relatively few states. This section presents data on enrollment and enrollment growth by state.<sup>9</sup>

Overall, the highest levels of risk-plan enrollment are in western states (Figure 2-7 and Table 2-5). In particular, more than one-fourth of the beneficiaries in three western states were in risk plans in 1996—California (35 percent), Arizona (34 percent), and Oregon (27 percent). The only eastern states where enrollment topped 10 percent were Florida (22 percent), Pennsylvania (16 percent), Massachusetts (14 percent), and Rhode Island (12 percent).

**Figure 2-7. Medicare Risk-Plan Enrollment, by State, December 1996 (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of Medicare Managed Care Contract Report (HCFA 1996c).

<sup>9</sup> These data are based on HCFA's monthly reports on managed-care plans. Adjustments could be applied to these data, however, to correct some small misrepresentations of enrollment patterns. In its monthly reports, HCFA allocates enrollment to the state where the plan is headquartered, not where its service areas are located. In June 1996, 7 risk plans were headquartered outside their service areas, and 18 had service areas in multiple states. Although no more than 3 percent of any state's beneficiaries are misallocated, this number compares with only 10 percent of beneficiaries in managed care in June 1996. The largest undercounts were in Delaware, Kansas, and Washington. The largest overcounts were in Oregon, Rhode Island, and the District of Columbia. Enrollment from the individual-level data for June 1996 are shown in Table 2-1.



**Table 2-5. Enrollment in Medicare Risk Plans, 1995 and 1996**

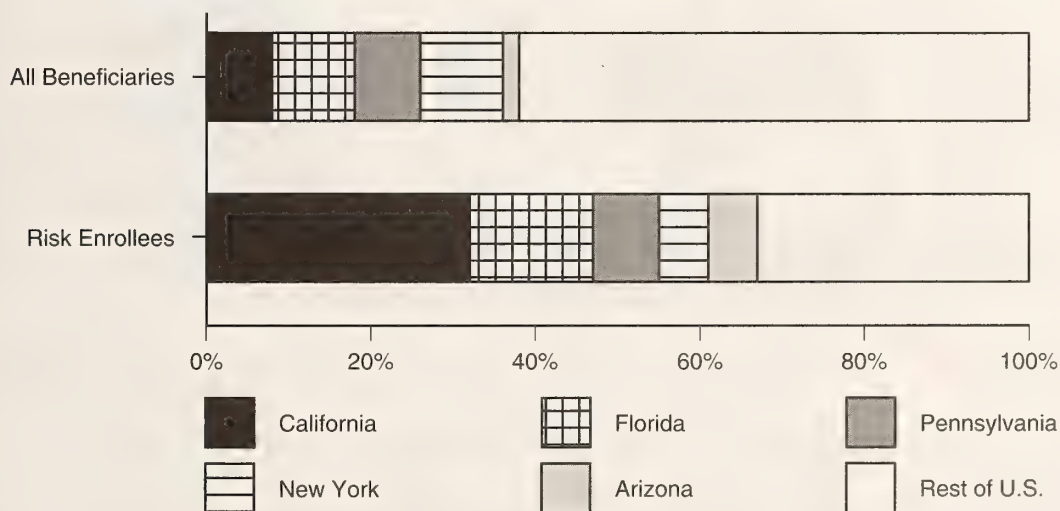
State	Number of Risk-Plan Enrollees 1995	Percentage of Beneficiaries 1995	Number of Risk-Plan Enrollees 1996	Percentage of Beneficiaries 1996
United States	3,069,962	8.2%	4,109,537	11.0%
Alabama	11,868	1.8	21,228	3.2
Alaska	0	0.0	0	0.0
Arizona	182,205	29.7	208,534	34.0
Arkansas	0	0.0	4,898	1.1
California	1,153,180	31.2	1,305,254	35.3
Colorado	73,113	17.0	94,876	22.0
Connecticut	2,438	0.5	12,010	2.4
Delaware	0	0.0	0	0.0
District of Columbia	4,352	5.5	9,804	12.4
Florida	469,688	17.6	573,460	21.5
Georgia	0	0.0	5,072	0.6
Hawaii	13,555	8.9	14,153	9.3
Idaho	0	0.0	0	0.0
Illinois	75,917	4.6	102,259	6.2
Indiana	3,311	0.4	3,740	0.4
Iowa	0	0.0	0	0.0
Kansas	0	0.0	1,520	0.4
Kentucky	5,177	0.9	8,195	1.4
Louisiana	32,511	5.5	51,742	8.8
Maine	0	0.0	0	0.0
Maryland	10,965	1.8	42,441	6.9
Massachusetts	79,387	8.4	135,178	14.2
Michigan	7,408	0.5	17,934	1.3
Minnesota	58,974	9.2	60,162	9.4
Mississippi	0	0.0	0	0.0
Missouri	32,939	3.9	70,939	8.4
Montana	0	0.0	0	0.0
Nebraska	3,626	1.4	5,548	2.2
Nevada	46,679	23.6	40,241	20.3
New Hampshire	0	0.0	0	0.0
New Jersey	19,989	1.7	77,169	6.5
New Mexico	31,480	14.6	36,037	16.7
New York	159,342	5.9	260,690	9.7
North Carolina	0	0.0	1,743	0.2
North Dakota	0	0.0	0	0.0
Ohio	31,010	1.8	80,337	4.7
Oklahoma	17,179	3.5	25,939	5.2
Oregon	110,950	23.3	128,945	27.1
Pennsylvania	163,902	7.8	327,605	15.6
Rhode Island	15,416	9.0	21,282	12.4
South Carolina	0	0.0	2,672	0.5
South Dakota	0	0.0	0	0.0
Tennessee	0	0.0	2,347	0.3
Texas	152,249	7.2	205,741	9.7
Utah	0	0.0	11,877	6.2
Vermont	0	0.0	0	0.0
Virginia	5,010	0.6	5,692	0.7
Washington	95,649	13.6	128,091	18.3
West Virginia	0	0.0	0	0.0
Wisconsin	493	0.1	4,182	0.5
Wyoming	0	0.0	0	0.0

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1995a; HCFA 1996c).

At the other end of the spectrum, nine states have no Medicare managed-care enrollment.<sup>10</sup> Several other states have negligible levels of enrollment. Generally, these states are rural, although enrollment is low in more urbanized states like Connecticut, Georgia, Michigan, and Wisconsin. Moreover, Connecticut and Wisconsin have levels of commercial managed-care enrollment above the national average. The relationship between commercial enrollment and Medicare enrollment is described in Chapter 3.

As demonstrated previously, Medicare's risk program is clustered geographically. Five states account for two-thirds of all risk enrollees, compared with only one-third of all Medicare beneficiaries (Figure 2-8). Almost half of all enrollees live in California and Florida, which account for only about 16 percent of all beneficiaries.

**Figure 2-8. Distribution of Medicare Beneficiaries and Risk Enrollees, by State, December 1996**



SOURCE: Physician Payment Review Commission analysis of Medicare Managed Care Contract Report (HCFA 1996c).

Growth in Medicare risk enrollment can be measured in at least two different ways.<sup>11</sup> The traditional definition of growth is the change in enrollment from one period to the next. With this definition, national growth from December 1995 to December 1996 was 34 percent. Growth was generally highest where enrollment levels were low or moderate. In these states, even relatively few new enrollees led to large growth rates.

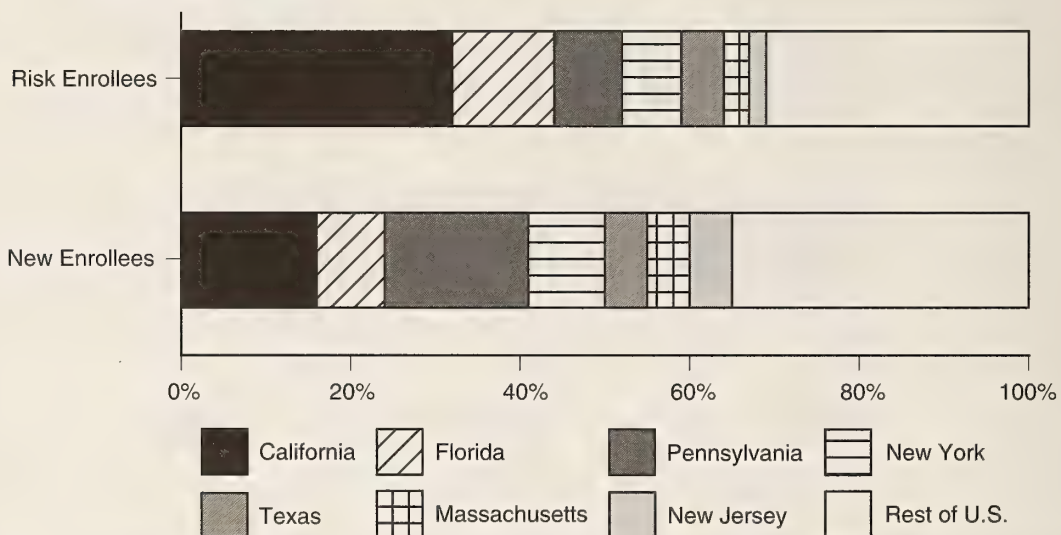
<sup>10</sup> HCFA's monthly report for December 1996 shows 13 states without any risk-plan enrollment. As described in footnote 9, enrollees in Delaware, Iowa, New Hampshire, and West Virginia are misallocated in that report.

<sup>11</sup> Maps displaying growth rates are in the Commission's chart book (PPRC 1996b). See also 1995 and 1996 enrollment by state in Table 2-5.

The second way to measure growth looks at new enrollees as a percentage of all beneficiaries in the state. The definition avoids a potentially misleading reliance on past levels of enrollment and focuses on those states where enrollees are joining most rapidly. About 2.8 percent of all beneficiaries joined risk plans during 1996. Using this definition, growth rates were generally greater where enrollment was already high. There are some exceptions; growth was relatively high in certain states (e.g., Maryland, Missouri, and New Jersey) where in past years enrollment has lagged below the national average.

Overall, new enrollees come from a somewhat different mix of states than do current risk enrollees. Beneficiaries in California and Florida represent 46 percent of all risk enrollees, but only 25 percent of those enrolling between December 1995 and December 1996 (Figure 2-9). Pennsylvania has a larger share of new enrollees (16 percent) than any other state.

**Figure 2-9. Distribution of Medicare Risk Enrollees and New Enrollees, by State, December 1996**



SOURCE: Physician Payment Review Commission analysis of Medicare Managed Care Contract Reports (HCFA 1995a; HCFA 1996c).

NOTE: New enrollees are measured as net change in enrollment from December 1995 to December 1996.

### Enrollment Patterns by Market

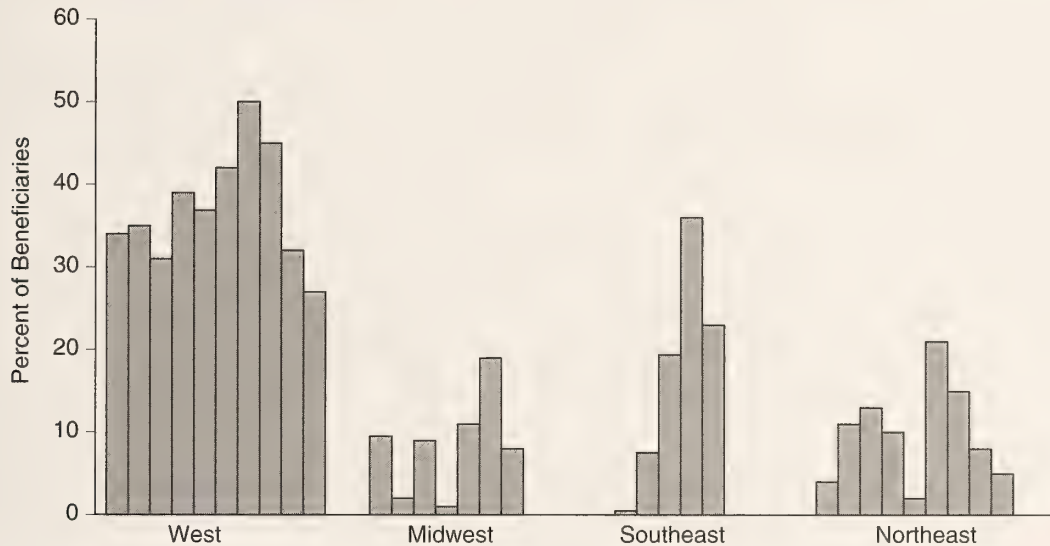
At the market level, there is considerable variation in risk-plan enrollment (Figure 2-10 and Table 2-2).<sup>12</sup> The highest enrollment levels are mostly in western markets like Riverside (51 percent), San Diego (46 percent), Tucson (44 percent), and Portland (43 percent). Many of the smaller markets in California also have enrollment levels above 30 percent.

<sup>12</sup> The figure and table display only those PMSAs with a population of greater than 1.5 million persons.



In the southeast, enrollment ranges from less than 1 percent (Atlanta) to 40 percent (Ft. Lauderdale). Several other Florida markets also top 30 percent. High enrollment levels are also found in some smaller markets in Texas and Louisiana, such as San Antonio (29 percent) and Baton Rouge (21 percent).

**Figure 2-10. Medicare Risk-Plan Enrollment in 31 Large Primary Metropolitan Statistical Areas, June 1996 (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration enrollment data.

**NOTE:** This figure includes 31 primary metropolitan statistical areas with populations over 1.5 million.

Enrollment is generally lower in northeastern and midwestern markets. The highest enrollment among large markets in the Midwest is in Minneapolis (19 percent), a market with a high commercial managed-care presence but low Medicare payment rates. The highest enrollment among the largest northeast markets is in Philadelphia (21 percent). But enrollment is also relatively high in Worcester, Massachusetts (29 percent), and Williamsport, Pennsylvania (23 percent).

In 6 of the 31 largest markets, enrollment remains at 5 percent or less—Atlanta, Baltimore, Cincinnati, Detroit, Newark, and Washington. While most of these markets are characterized by a relatively low managed-care presence, some (e.g., Baltimore) have substantial commercial enrollment.

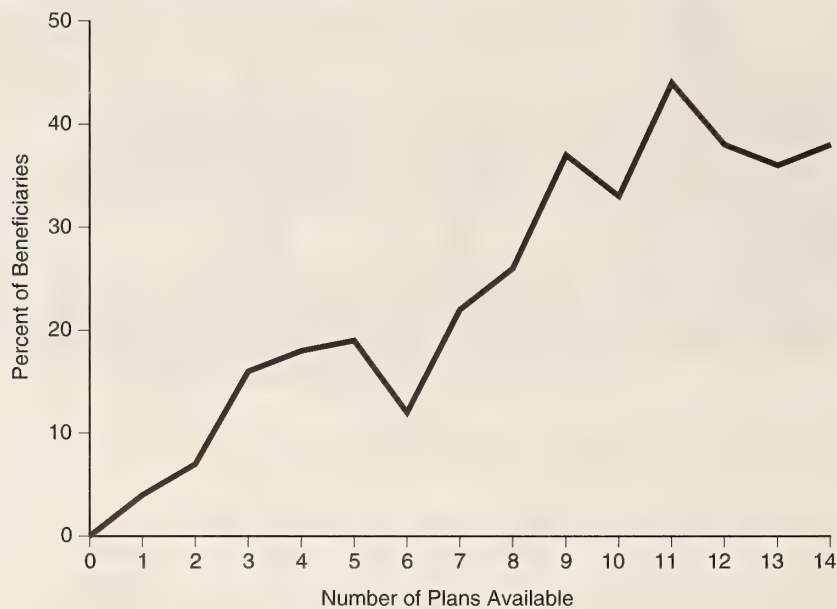
### Plan Availability and Enrollment

In general, there is a correlation between the number of plans available to a beneficiary and the likelihood of being enrolled in a risk plan. As noted earlier, however, areas with a broad choice of plans (at the market level or the state level) may have substantially different levels of enrollment. For

example, among markets where most residents are served by five or more plans, enrollment varies from 12 percent in Boston to 51 percent in Riverside.

A more systematic approach to this question is to consider the proportion of beneficiaries enrolled in risk plans at different levels of plan availability. Fewer than 10 percent of beneficiaries who live in an area served by two or fewer plans have enrolled in a plan. By contrast, more than 30 percent of those in areas with nine or more plans are enrolled in one of those plans (Figure 2-11). Further discussion of the relationship between availability and enrollment is presented in Chapter 3.

**Figure 2-11. Medicare Risk-Plan Enrollment, by Number of Plans Available in Area, June 1996 (percentage)**



SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration enrollment and geographic service area data.

## **PAYMENTS TO PLANS, BENEFITS, AND PREMIUMS**

Many of the policy issues that have been important in recent discussions of Medicare managed care have to do with the payments Medicare makes to the plans, the benefits some enrollees receive beyond those in traditional Medicare, and the premiums plans charge their enrollees. This section presents some basic background information on these matters. Further analysis of these issues and the Commission's proposals for change are in Chapter 3.<sup>13</sup>

<sup>13</sup> Previous Commission analysis of payments to plans and recommendations to the Congress are found in Chapter 5 in each of the 1995 and 1996 annual reports to Congress (PPRC 1995; 1996a).

There are two basic components of the risk program payment methodology. The first is the adjusted average per capita cost (AAPCC)—the actuarial method used to calculate risk-plan payment rates each year. The second is the adjusted community rate (ACR) mechanism through which risk plans determine the amount of Medicare noncovered benefits they will provide to Medicare enrollees and the premiums they can charge for those benefits. The payment methodology was designed to guarantee, first, that Medicare pays no more for a beneficiary who enrolls in a risk plan than it pays, on average, for one who stays in fee for service. Second, the system should ensure that no plan makes a proportionately larger profit on its Medicare business than on its commercial business.

**National Medicare per Capita Expenditures.** First, HCFA actuaries use historical program expenditures to project national per capita program expenditures for the coming calendar year. This estimate is known as the U.S. per capita cost (USPCC). Separate projections are made for Part A services and for Part B services for the aged, the disabled, and people with end-stage renal disease (ESRD). Fee-for-service claims for services provided three years earlier are used to ensure that the calculation is based on complete data. Projections for the current year take into account expected inflation and changes in utilization patterns and services covered by the Medicare program. The USPCCs are reported as monthly per capita expenditures, because risk plans are paid on a monthly basis. For aged beneficiaries, the 1997 monthly USPCC is about \$467 (Table 2-6).<sup>14</sup>

**Table 2-6. Projected Monthly U.S. per Capita Costs, by Medicare Part and Beneficiary Eligibility Status, 1997 (dollars)**

Medicare Part	Beneficiary Eligibility Status		
	Aged	Disabled	End-Stage Renal Disease
Part A	\$297.81	\$251.92	\$1,485.79
Part B	169.14	149.06	2,375.41
Total	466.95	400.98	3,861.20

SOURCE: HCFA 1996e.

### Payments to Risk Plans

Medicare pays risk plans based on an actuarial projection of what the program would have paid if the beneficiary had remained in the traditional fee-for-service sector. HCFA recalculates these plan payment rates every calendar year based on an estimate of national average spending, adjusted for differences by county. Actual payments to plans are then based on the characteristics of the beneficiaries who enroll.

**County-Level Medicare per Capita Expenditures.** In the second stage, HCFA estimates expected per capita program expenditures for aged and disabled beneficiaries in each county, and for people with ESRD in each state. The resulting amount is called the AAPCC. County-level per capita spending

<sup>14</sup> Payments to plans are lower on average, as described later in the chapter.



differs from the national average for a variety of reasons, many of which cannot be precisely measured. These factors include differences in input prices, practice patterns, health status, utilization, and Medicare payments for special purposes such as graduate medical education and support for hospitals with a disproportionate share of low-income patients. In making this calculation, the effect of year-to-year swings in per capita payments is reduced by using five years of fee-for-service claims data.

Risk adjusters are applied to these data to approximate what Medicare per capita spending in the fee-for-service sector would have been if a county had the same demographic characteristics as the nation as a whole. The risk adjusters used by Medicare in 1997 are age, sex, disability status, institutional status, Medicaid enrollment, and status as working aged with employment-based insurance coverage (Table 2-7).

**Table 2-7. Medicare Demographic Risk Adjusters for Aged Beneficiaries, 1997**

**PART A—Hospital Insurance**

Sex and Age Group	Institutional	Non-Institutional		
		Medicaid	Non-Medicaid	Working Aged
Male				
85 and Over	2.25	2.60	1.35	.90
80-84	2.25	2.35	1.20	.80
75-79	2.25	1.95	1.05	.70
70-74	2.25	1.50	.85	.45
65-69	1.75	1.15	.65	.40
Female				
85 and Over	2.10	2.10	1.20	.80
80-84	2.10	1.70	1.05	.70
75-79	2.10	1.45	.85	.55
70-74	1.80	1.05	.70	.45
65-69	1.45	.80	.55	.35

**PART B—Supplementary Medical Insurance**

Sex and Age Group	Institutional	Non-Institutional		
		Medicaid	Non-Medicaid	Working Aged
Male				
85 and Over	1.95	1.70	1.15	1.00
80-84	1.95	1.70	1.15	.90
75-79	1.95	1.55	1.10	.80
70-74	1.80	1.35	.95	.65
65-69	1.60	1.10	.80	.45
Female				
85 and Over	1.65	1.25	1.00	.85
80-84	1.65	1.25	.95	.75
75-79	1.65	1.25	.95	.70
70-74	1.65	1.15	.85	.55
65-69	1.50	1.05	.70	.40

SOURCE: HCFA 1996e.

NOTE: Values indicate the multiplier used for a beneficiary with a particular set of characteristics; average beneficiary has a multiplier of 1.00.

In an effort to claim savings for the government, Medicare actually pays plans at the rate of 95 percent of these adjusted county-level per capita expenditures. The resulting payment amount is often referred to as the AAPCC, but would more properly be labeled an AAPCC-based payment rate. (As described in the Social Security Act, the AAPCC is the amount before the 95 percent reduction is taken.) Whether the government actually realizes the intended savings depends on the accuracy of the various calculations, in particular, the adequacy of the risk adjusters (see Chapters 3 and 4).

**Enrollee-Level Payment to Plans.** Actual payments to plans depend on the characteristics of the beneficiaries who enroll. The AAPCC-based payment rate for an enrollee's county of residence (or state, in the case of ESRD enrollees) is adjusted by the national risk adjusters to reflect each enrollee's demographic characteristics (Table 2-8).

**Table 2-8. Calculation of Risk-Plan Monthly Payment on Behalf of Selected Beneficiaries, Los Angeles County, California, 1997**

	Part A (AAPCC × Risk Adjuster)	+	Part B (AAPCC × Risk Adjuster)	=	Total Payment
Male, Age 68 Non-Medicaid Noninstitutionalized Nonworking	$(\$396.59 \times 0.65)$	+	$(\$225.86 \times 0.80)$	=	\$ 438.47
Female, Age 87 Non-Medicaid Institutionalized Nonworking	$(\$396.59 \times 2.10)$	+	$(\$225.86 \times 1.65)$	=	\$1205.51

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996e).

NOTE: The monthly payment for an average beneficiary in Los Angeles County is \$622.55.

**Range of AAPCCs.** Among the approximately 3,000 counties in the United States, there is a substantial range around the average monthly payment for aged beneficiaries. The lowest AAPCC-based payment rates are \$221 in two rural Nebraska counties (Arthur and Banner). The highest are \$767 and \$748, respectively, in Richmond County, New York (Staten Island), and Dade County, Florida (Miami). Despite these extreme values, about half of all beneficiaries live in counties with 1997 rates between \$390 and \$530.<sup>15</sup>

On average, AAPCC-based payment rates are highest in urban areas and lowest in the most rural areas (Figure 2-12). The average payment in central urban counties is more than \$100 above that for other

<sup>15</sup> Because more plans are available where payment rates are high, half of all plan enrollees are in counties where rates are between \$455 and \$575.

urban counties and about \$160 above that for rural counties. The range within each of the urban-rural categories remains substantial, however.<sup>16</sup>

**Figure 2-12. Spread of County Payment Rates, by Urban and Rural Location, 1997**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996e).

**NOTES:** Three county payment rates are presented for each category: the minimum and maximum rate among the counties and the mean weighted by the number of beneficiaries per county.

Central urban counties are defined as the central counties in metropolitan areas of 1 million population or more; other urban refers to other counties in those metropolitan areas and any county in smaller metropolitan areas. Rural-urban fringe counties are defined as those nonmetropolitan counties that are adjacent to a metropolitan area, and other rural refers to nonmetropolitan counties not adjacent to a metropolitan area.

In the largest PMSAs that consist of more than a single county, AAPCC-based payment rates range widely both within and across markets (Figure 2-13). For example, plans serving the New York City area are paid an average of \$679, compared with \$396 in Minneapolis-St. Paul. These differing levels

<sup>16</sup> The averages presented are weighted by the number of beneficiaries in each county. It is also interesting to consider averages weighted by the number of enrollees in each county. The difference between the two means shows that enrollment is disproportionately higher in those counties where the AAPCC is higher. For example, the national enrollee mean is about 10 percent higher than the beneficiary-weighted mean. The differences between the two means are much less than the overall range of AAPCCs, however.



appear to have a substantial effect on plan participation in the Medicare risk program and in turn on beneficiary enrollment (see Chapter 3).

Moreover, within many PMSAs, this range is \$150 or greater per month.<sup>17</sup> Plans competing in the same market may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. As noted above, payment differences may also affect which areas a plan agrees to serve.

**Figure 2-13. Spread of County Payment Rates within Selected Primary Metropolitan Statistical Areas, 1997**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996e).

**NOTE:** Three county payment rates are presented for each primary metropolitan statistical area: the minimum and maximum payment rate among the counties in the PMSA and the mean weighted by the number of beneficiaries per county.

<sup>17</sup> These results are affected by the number of counties in a PMSA. Obviously, there is no range for a PMSA that consists of only one county (e.g., Los Angeles), and there is more potential for a wide variation in a PMSA with many counties (e.g., Washington, D.C., with 20 counties or similar jurisdictions).

## Adjusted Community Rate Requirements

Medicare's payment method is structured so that a plan cannot earn a higher return from its Medicare business than it does in the commercial market. If payments exceed a plan's cost, these savings must either be returned to the Medicare program or be used to finance extra noncovered benefits to enrollees.<sup>18</sup> In practice, only the latter option is used. The adjusted community rate is used to calculate the value of additional noncovered benefits in order to determine whether this requirement is met. Cash rebates to enrollees are not permitted as an alternative to providing extra noncovered benefits.

**The Basic ACR Calculation.** Each year plans that wish to enter into or continue risk contracts are required to submit an adjusted community rate proposal for the following calendar year (Table 2-9).<sup>19</sup> The ACR process requires a plan to use costs and revenues from its commercial business to estimate the cost of providing services to Medicare enrollees. Costs are adjusted to reflect differences between the plan's Medicare and commercial enrollees with regard both to utilization and intensity of services and to covered benefits. The plan's commercial revenues are used to calculate an allowance for administrative costs and profits. The average value paid by Medicare beneficiaries in cost sharing is subtracted from the cost of benefits to determine the ACR. In 1995, the average plan had an ACR of \$360.10 per month.

**Table 2-9. Calculation of Adjusted Community Rate, Using National Average Amounts, 1995 (dollars)**

Component	Unweighted Average	Weighted Average*
Cost of Covered Benefits + Administrative Overhead	\$425.18	\$433.14
Less: Average Fee-for-Service Cost Sharing	-65.08	-65.08
Adjusted Community Rate	360.10	368.06
Average Payment Rate by Medicare	382.27	409.97
Less: Adjusted Community Rate	-360.10	-368.06
Savings	25.17	41.91
Additional Benefits	32.08	35.02
Net Waived Cost Sharing	+49.76	+51.59
Less: Savings	-25.17	-41.91
Maximum Monthly Premium	56.67	44.70
Premium to be Charged	22.04	17.65
Waived Premium	34.63	27.05

SOURCE: Physician Payment Review Commission analysis of 1995 adjusted community rate proposals.

\* Weighted averages are based on the number of enrollees in each risk plan.

<sup>18</sup> A third option is to put some or all of this amount into a benefit stabilization fund, which could be drawn on in the future to avoid fluctuations in benefits from year to year.

<sup>19</sup> This discussion of the ACR requirements draws in part on papers prepared by ProPAC staff in November 1994, April 1995, and December 1996.

**Additional Benefits, Cost Sharing, and Allowable Premiums.** If expected Medicare revenues exceed projected costs, plans must provide additional benefits to Medicare enrollees. The estimated “savings” is calculated as the difference between the projected costs and expected revenues. In 1995, the average plan had a savings of \$25.17 per month—about 6 percent of its payment from Medicare (Table 2-9). Because beneficiaries tend to join plans with more benefits, the average enrollee was in a plan with \$41.91 in savings—10 percent of Medicare’s payment. Plans must provide benefits at least equal in value to the savings. Plans may choose which additional benefits to offer, including reduced beneficiary cost sharing.

Plans may offer additional noncovered benefits beyond those required to spend the savings. They are permitted to collect more from enrollees for these benefits through a combination of copayments and premiums. By law, total cost sharing and premiums charged to plan enrollees may not exceed the expected cost of the extra benefits (beyond those required to cover the savings) plus the national average amount of beneficiary cost sharing for Medicare-covered services in fee-for-service Medicare. In 1995, the maximum monthly premium for the average plan was \$56.67 (\$44.70 for the average enrollee) (Table 2-9).

Plans, however, may choose to waive part or all of the allowable premium. Plans must report on their ACR proposals the maximum premium that will be charged to any Medicare enrollee. In 1995, the average waived premium was \$34.63 per month, or about 60 percent of the allowable premium (Table 2-9).

### **Additional Benefits Offered and Premiums Charged by Plans**

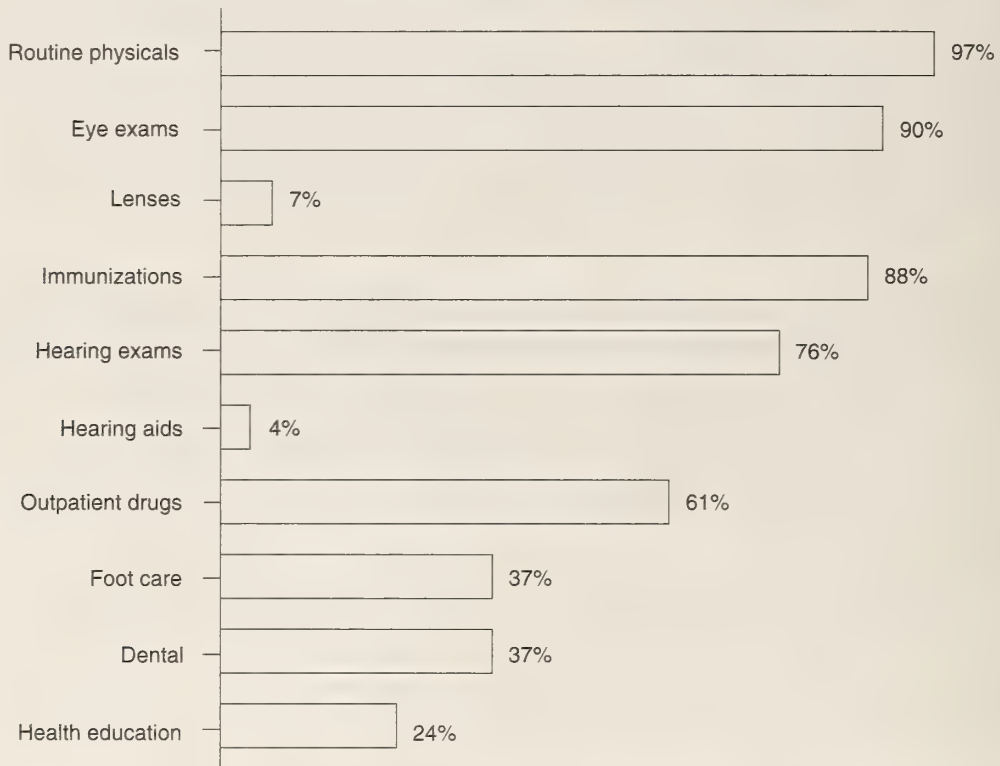
Nearly all plans offer some additional benefits to enrollees beyond those in the standard Medicare benefit package. These include both benefits offered to meet the requirements of ACR rules and optional benefits the plan chooses to offer to attract enrollees. Benefits widely available in December 1996 included routine physicals, eye exams, and immunizations (Figure 2-14). More than half the plans offered outpatient drugs as an additional benefit in their basic package. About 40 percent offered some type of high-option package besides their basic package.

As noted above, risk plans charge different premiums to enrollees for these benefits. Nearly two-thirds of plans in December 1996, however, charged no premium for their basic package (Figure 2-15). The proportion of zero-premium plans increased by more than one-fourth in the past year. One in six plans charged a monthly premium of over \$40 for the basic package.

It is important to understand the interaction between plans and benefits that results from the ACR rules. As noted above, the average plan in 1995 included benefits worth about \$25 per month to meet its ACR requirement (Table 2-9). The average plan offered another \$57 in benefits to meet the demands of the marketplace (referred to in the ACR proposal as the maximum monthly premium) and charged \$22 for these benefits. Thus, the average plan offered about \$60 in net value (\$82 in benefits for a \$22 premium).

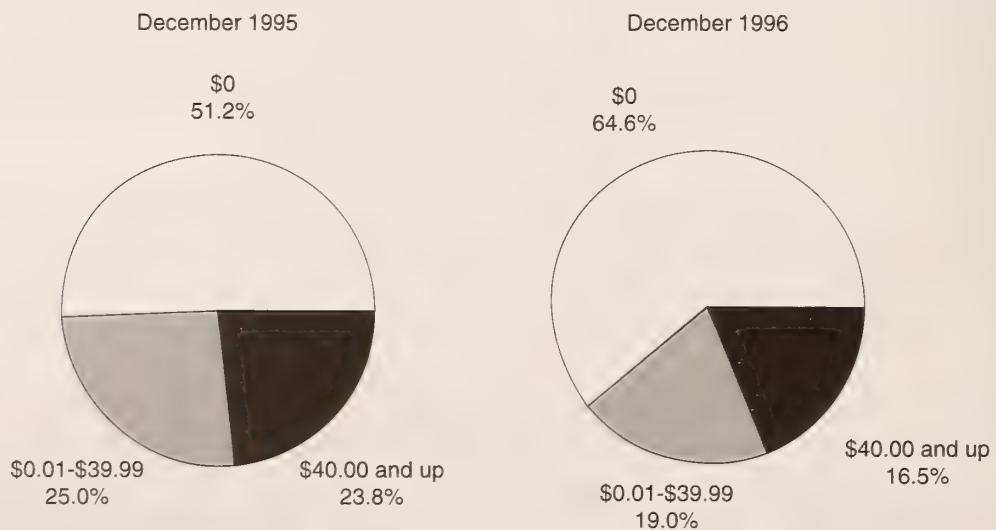


**Figure 2-14. Additional Benefits Medicare Risk Plans Offer in Their Basic Option Package, December 1996 (percentage of risk plans)**



SOURCE: HCFA 1996b.

**Figure 2-15. Distribution of Medicare Risk Plans by Monthly Premium Charged, 1995-1996**



SOURCE: HCFA 1995a; HCFA 1996c.

Because enrollment levels vary extensively among plans, these averages can be recalculated, weighted by enrollees (Table 2-9). As expected, beneficiaries disproportionately enroll in plans with high benefits and low premiums. As a result, the average enrollee received about \$69 per month in net benefits (\$87 in benefits for an \$18 premium). From a policy perspective, the latter figures are more helpful because they give more weight to the plans with more enrollees.

### Benefits and Premiums at the Market Level

Because competition among plans takes place at a market level, national data do not reveal how additional benefits received by plan enrollees vary by market. Analysis of the components of the 1995 ACR proposals at the market level provides some evidence on this issue.

In Miami, which has one of the highest payment rates in the country, plans have an average savings of over \$100 per month, meaning that they are required to provide this amount to beneficiaries in benefits (Table 2-10).<sup>20</sup> Including optional benefits, they provide a total of over \$125 in benefits for no premium. By contrast, in nonmetropolitan Florida, the payment rate and the amount of required benefits are much lower. Plans there hold their monthly premiums below \$10 by waiving a substantial premium.

**Table 2-10. Risk-Plan Benefits and Premiums Based on Adjusted Community Rate Proposals, by Market, 1995 (dollars per month)**

Primary Metropolitan Statistical Area	Number of Plans	Medicare Payment	Required Benefit Value	Optional Benefit Value	Premium Charged
United States	174	\$382.27	\$25.17	\$56.67	\$22.04
Boston	8	360.06	4.09	71.56	47.84
Chicago	3	418.79	24.45	38.31	0.00
Los Angeles	13	462.88	68.83	37.18	6.08
Miami	8	488.65	106.27	20.75	0.00
Minneapolis	3	333.93	0.00	75.89	60.97
New York	5	465.95	53.37	46.77	8.80
Philadelphia	6	434.12	19.30	66.85	10.00
Portland, OR	7	315.07	9.38	64.52	46.00
San Francisco	8	390.51	21.50	56.96	20.25
Nonmetropolitan California	6	369.00	14.43	60.19	31.08
Nonmetropolitan Florida	5	353.36	12.46	73.61	9.80
Nonmetropolitan Pennsylvania	3	402.32	6.70	62.18	18.14

SOURCE: Physician Payment Review Commission analysis of 1995 adjusted community rate proposals.

NOTES: Required benefit value is equal to Medicare savings in the adjusted community rate proposal; optional benefit value is equal to the maximum monthly premium.

Values are unweighted averages of all Medicare risk plans.

<sup>20</sup> Plan payment rates, as used in this analysis, are the weighted average county payment rates for all the counties in a plan's service area. To the extent that plans serving a particular community may have different overall service areas, they will receive different payment rates from Medicare.

Where Medicare payment rates are lower, plans typically provide fewer benefits. In Minneapolis, for example, plans' revenues match their adjusted costs (i.e., the savings amount is zero), so that beneficiaries receive no required additional benefits. Plans offer about \$76 in optional benefits, but charge a \$61 monthly premium. The pattern in Portland is similar.

Another example comes from a comparison of Los Angeles and San Francisco. Los Angeles plans are paid about \$72 more per month than those in San Francisco. As a result, beneficiaries are offered \$47 more in required benefits in Los Angeles than in San Francisco. San Francisco plans provide more optional benefits, but charge higher monthly premiums to do so.

There may also be differences in the benefits offered by plans within market areas. To consider this question, the Commission looked at three benefits (prescription drugs, hearing exams, and dental services). These three benefits have the most variation in whether they are offered by plans. They were examined across several markets, generally those with the largest number of plans.

Benefits and premiums appear fairly uniform within some markets (Table 2-11). Nearly all plans in the Miami market offer the three optional benefits and do so at a zero premium. In two markets with relatively low payment rates (Minneapolis and Portland), all plans charge some premium while offering fewer additional benefits. In addition, more benefit variation exists among plans in Minneapolis and Portland than among those in Miami.

**Table 2-11. Risk-Plan Benefits and Premiums, by Market, June 1996**

Primary Metropolitan Statistical Area	Number of Plans	Percentage of Plans Offering			
		Drug Benefit	Hearing Exam Benefit	Dental Benefit	Zero Premium
United States	190	62%	74%	38%	65%
Boston	9	11	78	33	44
Chicago	5	40	80	60	100
Los Angeles	15	87	67	60	87
Miami	9	100	100	89	100
Minneapolis	3	0	100	67	0
New York	10	100	90	50	100
Philadelphia	11	91	100	55	91
Portland, OR	7	15	43	0	0
San Francisco	11	82	91	27	55
Nonmetropolitan California	7	71	57	28	14
Nonmetropolitan Florida	7	100	57	14	57
Nonmetropolitan Pennsylvania	6	50	83	67	67

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996c).



In Los Angeles, most plans include drug benefits and charge no premium, but vary in whether they offer hearing exams or dental benefits. By contrast, San Francisco plans are nearly equally divided on whether they charge a premium.

This analysis represents a starting point for studying the competition among plans in Medicare markets. The competitive environment is complex, however, and more research will be required to understand the dynamics of competition in the Medicare risk program. Additional work will include reanalysis of the patterns of premiums and benefits in markets (weighting by numbers of enrollees) and a more complete analysis of the full range of benefits provided. These issues, discussed further in Chapter 3, may help policymakers understand what factors lead to higher enrollment and how changes in payments to plans affect competition among plans for enrollees.

## REFERENCES

- Carbine, Michael E., "Crozer-Keystone Won't Capitate Providers; HCFA to Risk-Adjust Pay," *Managed Care Week: Provider Contracting and Capitation* 7(3):2-4, January 20, 1997.
- Health Care Financing Administration, Department of Health and Human Services, "Medicare Managed Care Contract Report," December 1995a.
- Health Care Financing Administration, Department of Health and Human Services, *The Point of Service Benefit for Medicare Beneficiaries Enrolled in Risk Plans: Guidelines* (Washington, DC: October 6, 1995b).
- Health Care Financing Administration, Department of Health and Human Services, "Clinton Administration Expands Managed Care Options for Medicare Beneficiaries," press release, December 27, 1996a.
- Health Care Financing Administration, Department of Health and Human Services, "Growth of Medicare Managed Care Plans: CYs 1985-96," *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement, 1996b, pp. 124-133.
- Health Care Financing Administration, Department of Health and Human Services, "Medicare Managed Care Contract Report," June 1996 and December 1996c.
- Health Care Financing Administration, Department of Health and Human Services, *Profiles of Medicare* (Washington, DC: May 1996d).
- Health Care Financing Administration, Department of Health and Human Services, "1997 Adjusted Average Per Capita Cost (AAPCC) for Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Risk Contractors," memorandum, September 6, 1996e.

Health Care Financing Administration, Department of Health and Human Services, "HCFA Expands Medicare 'Choices' Demonstration," press release, February 28, 1997.

Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).

Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996a).

Physician Payment Review Commission, *Medicare Risk Plan Participation and Enrollment: A Chart Book* (Washington, DC: December 1996b).

Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington, DC: June 1996).

# Revising the Method for Determining Medicare Capitated Payments

Interest in broadening the choices available to beneficiaries and curbing Medicare spending growth has focused attention on improving the method used to determine payments to health plans in the risk-contracting program. Recent growth in the risk program has further increased interest in this issue among policymakers. Many observers believe that current payment policies are too generous in certain markets, leading to needlessly high Medicare outlays. They argue that these policies keep Medicare from benefiting from any efficiencies resulting from beneficiaries' enrollment in managed care. Some think policies limit the program's expansion in certain markets. Others maintain that the government should be indifferent about whether beneficiaries choose managed care. In any case, current policies result in differences in the additional benefits offered and premiums charged by risk plans in various markets. The Physician Payment Review Commission recommends several strategies for improving risk-plan payment.

*Several modifications should be adopted to make the adjusted average per capita cost (AAPCC) a more reliable estimate of expected patient care costs. Among these are using better risk-adjustment methods; excluding payments to hospitals for graduate medical education expenses and serving a disproportionate share of low-income patients; including the cost of care currently provided by other institutions like the Departments of Veterans Affairs and Defense, which is likely to be furnished by managed-care plans; and basing the AAPCC on larger geographic areas.*

*This chapter includes:*

- *Problems with current Medicare capitated payment policies*
- *Recommendations for improving Medicare capitated payments*
- *Challenges of estimating the effect of policy changes on plans, beneficiaries, and the budget*

## *Recommendations*



*Once graduate medical education costs are removed from the AAPCC, new mechanisms should be developed to ensure that hospitals, managed-care organizations, and other training entities are paid fairly for these costs when they are involved in appropriate training activities. Medicare payment policies should be developed to pay for graduate medical education in various settings.*

*The net effect of alternative policy combinations must be considered. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk-plan payments will differ, depending on the exact combination of policies used and the order in which particular elements are introduced. Any changes in payment policy will affect the relationship between Medicare managed care and fee for service with regard to per capita outlays, benefits, and premiums. Changes should be designed and phased in to minimize disruptive effects on beneficiaries and plans.*

*If the AAPCC is the base for setting rates that are unlinked from fee-for-service spending, then it would be appropriate to make technical improvements to the AAPCC.*

*The Health Care Financing Administration should continue to test alternative methods for setting local payment rates, such as competitive bidding, partial capitation, and reinsurance.*

*Expansion of Medicare managed care raises issues beyond setting payments to plans. The Commission reiterates its recommendations on the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures which were described more fully in its Annual Report to Congress 1996.*

This chapter focuses on recommendations and issues related to setting capitated payments. Many of these recommendations also relate to a variety of other topics, such as risk adjustment, competitive approaches to setting rates, and strategies to reduce risk selection, which are discussed elsewhere in this report or in the Commission's *Annual Report to Congress 1996* (PPRC 1996).<sup>1</sup>

There are three distinct approaches to changing how Medicare pays managed-care plans. One set of proposals retains the current policy framework of basing payments on fee-for-service outlays, but makes technical improvements so that actual implementation is more consistent with policy intent. A

---

<sup>1</sup> See, for example, Chapters 4, 5, and 9 of this report.

second set uses current policy as a starting point and employs a variety of approaches, such as payment floors or blended national and local rates, to reduce differences in rates across counties. A third discards current policies altogether and uses specific information about local markets to develop local payment rates.

There is a tension between stimulating growth in the risk program and ensuring that payments in a particular market are not higher than necessary to attract plans and beneficiaries. Various approaches to changing payment policies have different implications for the benefits beneficiaries receive and the premiums they pay in both managed care and fee for service. Furthermore, changes in payment policies could result in per capita payments that differ from average outlays for fee-for-service beneficiaries in the same market, raising questions about how the two parts of Medicare should relate to each other.

Of increasing interest to policymakers, local market dynamics are central to any new payment policy's success at fostering broader choices and savings simultaneously. Estimates of the effect of alternative payment approaches are hampered, though, because little is known about plans' and beneficiaries' likely responses to changes in payment levels in different markets nationwide. As a result, the effects of different payment approaches on plan and beneficiary behavior and resulting program costs are difficult to predict.

This chapter begins by reviewing current policy and some of the concerns it raises. Alternative proposals to address those concerns are reviewed. The important role of risk adjustment in setting local base rates and payments to individual plans is discussed, as well as the implications of improved risk adjustment for payments under the current approach. Results from recent analyses of risk program participation are then summarized, along with some of the difficult analytic issues that such studies must confront.

## **CURRENT RISK-PAYMENT POLICY**

Medicare's risk-program payment rules are straightforward in concept, but complex in practice. They are motivated by two distinct goals. One is that per capita outlays should be no more when beneficiaries choose managed care than when they are in fee for service; the other, that plans should not earn excessive profits from serving Medicare beneficiaries. To meet the first goal, Medicare's capitation payment is based on a projection of its fee-for-service per capita spending in each county. To accomplish the second, each plan estimates its cost (plus normal markup) for providing basic Medicare coverage to enrollees. If Medicare's payment exceeds this estimate, the plan must rebate the difference to beneficiaries in the form of enhanced benefits or reduced cost sharing.<sup>2</sup> Plans may provide additional benefits to beneficiaries beyond those required as part of the basic Medicare package, either as required by this plan-specific cost calculation or in response to local competitive pressures.

---

<sup>2</sup> Plans have the option to return the surplus to the government, but none do.

## Payments to Plans

Payments to risk plans are set through a two-step process. First, local payment rates are established. These rates reflect how much Medicare would pay a plan for enrolling a nationally representative fee-for-service beneficiary in each county. Then, the payment level for an individual plan is set based on the characteristics of the beneficiaries who are actually enrolled in the plan. This two-step approach is designed to ensure that Medicare pays the same amount for risk plan enrollees as it would have had they remained in fee for service, while at the same time paying plans appropriately for the risk status of their enrollees. Local base payment rates are set at 95 percent of fee-for-service outlays, a reduction that is variously viewed as planned savings from managed-care enrollment or as an effort to withhold program administrative costs.

**Setting Local Base Rates.** Under current policy, local rates are supposed to reflect the expected outlays for a nationally representative beneficiary in each county, less 5 percent. They are based on estimates of the average amount of money Medicare spends annually for fee-for-service beneficiaries in each county. Since the characteristics of local Medicare beneficiaries differ across counties, the simple average per capita amount reflects the costs of caring for the unique mix of beneficiaries in each county. Therefore, to set local rates that reflect expected outlays for a nationally representative beneficiary, this average is adjusted for differences between each county's fee-for-service beneficiary population and the fee-for-service population nationwide.

The adjustment of per capita outlays reflects differences between the local and national population with regard to particular demographic factors, including age, sex, working status, institutional status, and welfare status.<sup>3</sup> If a county's fee-for-service beneficiaries include a disproportionate share of high-cost demographic groups, then it has an average demographic risk factor above the national average of 1.0. A county with low-risk beneficiaries has an average risk factor below 1.0. If a county has a high risk factor, its average fee-for-service outlays reflect, at least in part, the relatively high risk status of local beneficiaries. Thus, its average is not indicative of expected outlays for a nationally typical beneficiary. By dividing local outlays by the county's risk factor, the resulting adjusted average per capita cost (AAPCC) is less than actual per capita outlays, and suggestive of expected outlays for a more typical beneficiary mix. The actual local base payment rate is set at 95 percent of the AAPCC.<sup>4</sup>

For example, in Cook County, Illinois, gross Medicare per capita fee-for-service outlays in 1995 were \$490 (Table 3-1). Its demographic index was 0.96, meaning that the county had a disproportionate share of fee-for-service beneficiaries in lower-cost demographic groups. The AAPCC was \$511, reflecting expected fee-for-service outlays in Cook County if it had contained a more typical mix of beneficiaries. The local base payment rate was set at 95 percent of \$511, or \$485.

---

<sup>3</sup> The demographic risk factors are presented in Chapter 2, Table 2-7.

<sup>4</sup> The derivation of AAPCC-based rates is described more precisely in Chapter 2.



**Table 3-1. Derivation of Medicare Risk-Plan Payment Rates from Fee-for-Service Outlays, Selected Counties, 1995**

County	Average Medicare per Capita Cost	Demographic Risk Index	Adjusted Average per Capita Cost (AAPCC)	Base Payment Rate (95% of AAPCC)
Cook, IL	\$490.37	0.96	\$510.80	\$485.26
Dade, FL	686.85	1.06	647.97	615.57
Hennepin, MN	378.13	0.99	381.95	362.85

**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration 1995 AAPCC master file and published payment rates.

**NOTE:** The per capita costs reported here were derived from the demographic risk index and published payment rates. They are suggestive of, but not equal to, the true gross outlays in these counties that were used to calculate the adjusted per capita cost.

**Setting Payments for Individual Plans.** Beneficiaries' risk status varies not only across counties but also within them. As a result, individual managed-care plans may enroll beneficiaries who have, on average, very different expected costs owing to differences in risk status. Therefore, local AAPCC-based rates are adjusted for the characteristics of each plan's enrollees to establish the plan's payment rate. The same demographic factors used to create the AAPCC-based rates are used in this process, namely age, sex, working status, institutional status, and welfare status. If a plan enrolls beneficiaries who are likely to use more health care services than average because of their risk status, the plan receives payments that are higher than AAPCC-based rates. Conversely, if a plan attracts enrollees who are likely to use fewer services, then its payments are lower than the AAPCC-based rate.

Cook County is again illustrative. Even though its AAPCC-based rate was \$485 in 1995, four hypothetical plans with different enrollee mixes would have received payments that differed by nearly \$140 (Table 3-2). Plan A's enrollees were evenly spread across the 10 risk categories in this example, which resulted in an average payment of \$459, slightly less than the county base rate of \$485. Plan B's older enrollee group resulted in higher per capita payments of \$517. Plan C served a younger mix of enrollees that yielded an average payment of \$395, whereas Plan D, which served relatively more women than men, received the lowest average payment per enrollee of \$379.

**The Two-Step Process.** By establishing AAPCC-based rates for a typical beneficiary and then adjusting plan payments based on enrollee characteristics, Medicare is attempting to be both fair in its payments to plans and faithful to its concept of paying the same for plan enrollees (less 5 percent) as it would have if they had stayed in fee-for-service Medicare. Without the two-step process, Medicare is likely to grossly overpay or underpay plans in certain situations. For example, a county with a low-risk population is likely to have below-average fee-for-service outlays. If these are not adjusted in estimating AAPCC-based rates, the application of risk adjusters to determine plan payments will result, essentially, in double counting of risk status: lower-risk enrollees contributed first to the low

local rate and then to lower actual payments to plans. The two-step process would not be necessary if there was a separate set of risk adjusters for each county that reflected within-county cost variation relative to the county mean. Whether resulting payments are fair depends largely on the accuracy of the risk adjustments used first to set AAPCC-based rates and then to adjust these rates in paying individual plans.

**Table 3-2. Example of the Calculation of 1995 Payments to Four Hypothetical Risk Plans in Cook County, Illinois**

Demographic Group	Demographic Factor	Percent Enrollees in Risk Group			
		Plan A	Plan B	Plan C	Plan D
Women					
85+	1.096	10%	20%	3%	1%
80-84	1.014	10	15	5	5
75-79	0.886	10	10	10	14
70-74	0.754	10	5	15	18
65-69	0.604	10	3	20	25
Men					
85+	1.246	10	20	0	0
80-84	1.182	10	15	3	2
75-79	1.068	10	9	9	5
70-74	0.904	10	3	15	10
65-69	0.704	10	0	20	20
Average Per Capita Payment to Plans		\$459	\$517	\$395	\$379

NOTE: The 1995 base rate in Cook County was \$485.26. All enrollees were assumed to be non-institutionalized, not working, and not receiving Medicaid. Actual payments would be calculated from the separate demographic indexes for Part A and Part B. The demographic factor used here was created as a weighted average of the 1996 Part A and Part B factors, where weights reflect the composition of national Medicare spending (64 percent for Part A, 36 percent for Part B). They are, therefore, not equal to the adjustments that would have actually been made to plans based on the local mix of Part A and Part B spending and 1995 demographic factors.

### Establishing Risk-Plan Premiums and Benefits

The risk-adjusted payment from the Health Care Financing Administration (HCFA) to plans is only part of the payment process. For either competitive or regulatory reasons, plans may offer additional benefits to beneficiaries for little or no extra premiums. Most plans in fact offer significant benefits besides the Medicare benefit package, while only a minority charge beneficiaries a separate premium.

These premium and benefits offerings are affected, at least in part, by the Medicare rules designed to preclude excessive profits from Medicare enrollees. The policies were designed so that risk plans earn only a normal rate of return on their Medicare business, with any excess payments from Medicare or savings from managed-care efficiency passed on to the program or to beneficiaries. Plans are required

to estimate their cost (plus normal markup) for providing the basic Medicare benefits package. Plans base their estimate on their average commercial (non-Medicare) per capita costs, adjusted to account for higher rates of service use by the Medicare population. If Medicare's payment to the plan exceeds this adjusted community rate (ACR), the plan must rebate the difference either to Medicare or to beneficiaries in the form of increased benefits or lower cost sharing. In practice, all plans choose to use the excess payments to provide more benefits. The Commission's analysis of 1995 ACR data shows that risk enrollees received required additional benefits worth about 10 percent of total risk-plan payments because of the difference between HCFA's payments and plans' costs.<sup>5</sup>

Regardless of their regulatory ACR obligations, plans can offer a richer benefit package to beneficiaries. The actuarial value of these optional benefits can be charged to beneficiaries in the form of additional premiums. Plans generally waive some or all of these premiums, presumably reflecting competitive pressures in different markets. In 1995, enrollees received optional additional benefits worth, on average, nearly \$45, for which they paid an average of \$18.

As a result of the ACR process and competitive factors in different markets, benefits available to beneficiaries through risk plans and the premiums they must pay for these benefits vary. All plans in Miami, for example, charged no premium in 1996 for additional benefits and included coverage for prescription drugs and hearing exams, while all but one provided dental coverage (see Chapter 2, Table 2-11). By contrast, all three plans in Minneapolis charged premiums for additional benefits; none offered drug coverage, all offered hearing exams, and two covered dental care. In Chicago, all plans covered additional benefits for free, but they provided different mixes of these particular three benefits.

## CONCERNS ABOUT THE CURRENT SYSTEM

This section reviews some of the problems that have been identified with Medicare's AAPCC-based payment method. These problems, some of which are described in more detail elsewhere in this report and in previous Commission reports, have led to a variety of proposals to change current policies.<sup>6</sup> Proposed solutions to these problems are discussed later in this chapter, as well as in other chapters of this report.

**Inadequate Risk Adjustment.** Risk payments reflect the use of demographic risk adjustment at two distinct points—in setting AAPCC-based local rates and in determining payments to plans that reflect

---

<sup>5</sup> The ACR process and estimates are described more fully in Chapter 2.

<sup>6</sup> See, for example, Chapter 4 in this report, Chapter 5 in the Commission's 1996 annual report, and Chapter 5 in the 1995 annual report (PPRC 1996; 1995). These issues were also addressed in a report issued by the Commission with the Prospective Payment Assessment Commission, *Joint Report to the Congress on Medicare Managed Care*, October 1995 (PPRC and ProPAC 1995).



the characteristics of their enrollees. The effect on AAPCC-based rates of the limitations of the demographic risk factors currently used to set payments is briefly reviewed in this section.<sup>7</sup>

The inadequacies of the current demographic risk adjusters affect the accuracy of the AAPCC-based rates as a measure of the likely fee-for-service costs of a typical beneficiary. The AAPCC reflects only beneficiaries who remain in fee-for-service care. To the extent that current risk adjusters do not capture their poor health, expected fee-for-service payments for risk enrollees are overstated, a phenomenon called base-rate bias. For example, the 1996 Part A risk factor for noninstitutionalized women over 85 was 2.0, so that their Part A outlays were divided by 2 when the AAPCC was calculated. If, however, the only women over 85 remaining in fee-for-service Medicare in a particular county were exceptionally ill and used many health services, then their average fee-for-service outlays may have exceeded those of the standard beneficiary by more than the amount indicated by the demographic risk factor. As a result, the AAPCC would overstate outlays for the typical beneficiary.<sup>8</sup> Introduction of risk adjusters that capture differences in health status in the current AAPCC methodology would likely change AAPCC-based rates and make them more accurate measures of expected outlays for the standard beneficiary.

Current demographic risk adjustment does not fully adjust actual Medicare fee-for-service outlays for the differences in the health status of beneficiaries across counties. As a result, some of the variation in the AAPCC reflects differences in health risks across counties. More precisely, variation is due to differences in health risks of fee-for-service beneficiaries, which are in turn affected by the degree of selection for or against risk plans in each county. If the base-rate bias described above is significant and growing, it will result in more geographic variation in the AAPCC in coming years. In particular, geographic differences in enrollment in the risk program among risk groups will translate into variation in AAPCC-based rates.

**Wide Geographic Disparities in Rates, Enrollment, and Benefits.** The link between fee-for-service spending and risk-plan payments results in payment levels that vary widely across the nation and that change erratically from year to year in some areas. Medicare per capita fee-for-service outlays vary widely across areas because of differences in local prices, demographic composition, health status, and other factors like practice patterns and patient preferences. For example, local price differences account for only 13 percent of the variation in the AAPCC, which is local fee-for-service spending net of demographic differences.

AAPCCs are fairly volatile, particularly in less-populous counties where they are based on small numbers of fee-for-service beneficiaries. The anomalies that can result from small county populations are most easily seen by considering the AAPCC-based payment rate for Loving County, Texas. This rural county of fewer than 20 beneficiaries had the country's highest AAPCC-based rate in 1996, \$881.

---

<sup>7</sup> Risk adjustment is discussed more fully in Chapter 4.

<sup>8</sup> Commission analysis described in Chapter 4 reveals that at the time they enroll in risk plans, enrollees had Medicare costs during the previous year that were about 60 percent of the national average.

Since 1990, the AAPCC-based rate has had annual increases of over 70 percent two times and dropped over 10 percent in three different years. The 1997 rate is \$527.

Variation and volatility have implications for patterns of risk-plan enrollment, premiums, and benefits nationwide. They may contribute to an uneven distribution of enrollment, with none in some areas and significant numbers of enrollees in other areas. They account, at least partly, for the wide and apparently arbitrary discrepancies in the additional benefits beneficiaries get from risk plans in different markets. Plan benefit generosity largely appears to reflect variations in Medicare fee-for-service outlays and perhaps risk selection, rather than differences in plan efficiency. The Commission's analysis of 1995 ACR proposals from risk plans reveals a high correlation between the value of required additional benefits and local payment rates, while premiums charged for optional additional benefits are negatively correlated with local rates.

Benefits and premiums vary from year to year, partly because of AAPCC volatility. As risk-plan enrollment grows, both AAPCCs and benefits will be even more volatile from year to year, since the numbers of beneficiaries upon which the AAPCC calculations are based will shrink as risk enrollment increases. Current law provides a mechanism for plans to use excess payments in one year to insulate beneficiaries from changes in benefits caused by subsequent fluctuations in payment rates. Expanded use of this Benefit Stabilization Fund might help reduce erratic changes in plans' benefit offerings.

**Earmarked Funds in Fee-for-Service Spending.** Another issue related to the AAPCC is that fee-for-service outlays include special payments that perhaps should not be passed along to all managed-care plans. In particular, Medicare makes special payments to hospitals for graduate medical education (GME) and for serving a disproportionate share (DSH) of low-income patients. Together, these contribute 5.5 percent to the AAPCC nationwide, although the share varies widely across counties, from zero percent to more than 25 percent (Table 3-3).

Including these earmarked funds in AAPCC-based rates raises two distinct concerns. First, from a technical perspective, they are partially responsible for the geographic variation in the AAPCC, contributing to some of the particularly high values. Second, from a broader policy perspective, it is not clear whether it is appropriate to pass these payments along to all managed-care plans, since they are targeted to compensate specific hospitals for special circumstances beyond the costs of caring for Medicare patients. To the extent that managed-care plans incur these special costs, it may be appropriate to develop a way to pay them explicitly in relation to their GME and DSH costs, mirroring hospital payment policies.<sup>9</sup>

**Cost Increases Tied to Fee-for-Service Spending.** The link between risk-plan payments and fee-for-service outlays has profound implications for the growth of Medicare spending over time. Cost increases in Medicare fee for service drive cost increases throughout the program. Thus, insofar as

---

<sup>9</sup> Whether managed-care enrollees should be included in the measure of Medicare caseload used to calculate these special payments is a separate question.

increased managed-care enrollment raises AAPCC-based rates as described above, overall Medicare costs may actually climb as the risk program grows. Current efforts to promote Medicare managed care that do not address these issues may boost Medicare outlays.

**Table 3-3. Estimated Medical Education and Disproportionate Share Payments as Components of Medicare Risk-Plan Payment Rates, by Urban and Rural Location, 1995 (percentage)**

	Medical Education	Disproportionate Share	Total Percentage
All Counties	3.4%	2.1%	5.5%
Urban Counties	3.8	2.3	6.1
Central urban	5.3	3.1	8.4
Other urban	3.1	1.9	5.0
Rural Counties	2.1	1.5	3.6
Urban fringe	2.2	1.6	3.8
Other rural	1.9	1.5	3.4

SOURCE: Physician Payment Review Commission analysis of Medicare Part A expenditures for the 5 percent sample of beneficiaries for 1993, published payment rates for 1995, and risk-plan eligibility and enrollment data from the group health plan master file for mid-1995.

## IMPROVING RISK-PLAN PAYMENT POLICY

Recent discussions of changing the payment method have focused primarily on the wide geographic variation and year-to-year volatility of AAPCCs. These issues can be addressed either by making technical improvements to the current approach or by unlinking risk payments from fee-for-service outlays. Some of the changes described below may work well together. They may have different effects depending on how they are combined, however.

The Commission recommends analyzing the expected net effect of alternatives, which may depend on the sequence in which policies are implemented. Moreover, any change in risk-plan payments is likely to alter the relationship between the risk program and traditional fee-for-service Medicare with regard to per capita outlays, benefits, and premiums. Payment changes should be phased in to minimize disruptions to plans and beneficiaries.

### Technical Improvements to the AAPCC

The volatility and variation in the AAPCC reflect several factors, including inadequate risk adjustment and the use of counties as the geographic unit for determining payments. The Commission has recommended several technical improvements to setting AAPCC-based rates that would reduce geographic variation and volatility while making the rates more accurate estimates of patient care



costs. These changes should be made if the AAPCC continues to determine all or part of Medicare managed-care payments. These improvements would make the AAPCC a better, more stable estimate of fee-for-service outlays for the typical beneficiary. An improved AAPCC would clearly be desirable for the current policy goal of setting managed-care rates equivalent to fee-for-service costs. As discussed later in this section, it may also be appropriate even if the AAPCC is no longer the sole basis for setting payments.

**Improve Risk Adjustment.** The Commission recommends immediate implementation of better risk adjusters as part of risk plan payment policy. Gross estimates suggest that a risk-adjustment approach reflecting differences in health status across areas would result in AAPCCs with less geographic variation than current values have (Table 3-4). There is a high correlation between the AAPCC-based payment levels and a diagnosis-based risk index based on the hierarchical coexisting conditions (HCC) algorithm HCFA is using in its Medicare Choices demonstration.<sup>10</sup> Using this index to improve the AAPCC as an estimate of expected outlays for a typical beneficiary would result in more homogeneous local base rates. For example, the low AAPCC-based rate of \$363 in Hennepin County is due in part to the relatively low diagnosis-based risks of its fee-for-service beneficiaries, as indicated by a diagnosis-based risk index value of 0.89 for the Minneapolis metropolitan area.<sup>11</sup> If the diagnosis-based risk adjustment were made in setting base payments, Hennepin County's rate would be \$408. At the same time, the HCC adjustment would lower payment rates in Dade County from \$616 to \$459. Overall, the spread of the health-risk adjusted base rates is much smaller than that of current rates.

**Table 3-4. Effect of Diagnosis-Based Risk Adjustment on 1995 Medicare Risk-Plan Payment Base Rates, Selected Counties**

County	Average County Rate for Medicare Beneficiaries	Diagnosis-Based Index	Diagnosis-Adjusted Base Rate
Cook, IL	\$485.26	1.02	\$475.75
Dade, FL	615.57	1.34	459.38
Hennepin, MN	362.85	0.89	407.70

**SOURCE:** Physician Payment Review Commission analysis of 1995 Medicare claims, 5 percent sample of beneficiaries.

**NOTE:** Diagnosis-based index is based on hierarchical coexisting condition algorithm described in Chapter 4. Values are for the metropolitan area that contains each county.

<sup>10</sup> This algorithm is described more fully in Chapters 4 and 5.

<sup>11</sup> The HCC health status index was calculated from the Medicare 5 percent claims file, which cannot support estimates at the county level. As a result, MSA-level estimates are used here.

Under virtually any change to payment policy, improving risk adjustment of payments to plans would reduce incentives to avoid risk, promoting competition based on cost and quality. The use of HCCs and other risk-adjustment approaches is discussed in detail in Chapter 4. That chapter describes a variety of approaches that could be implemented immediately and that may be more appropriate than the 5 percent reduction in all payment rates proposed in the President's fiscal year (FY) 1998 budget.

**Remove Earmarked Funds from Fee-for-Service Base.** As described above, the inclusion of special payments for graduate medical education expenses and for disproportionate share hospitals exacerbates the geographic variation in the AAPCC. The Commission recommends removing these payments from the AAPCC. The Senate's version of the Balanced Budget Act of 1996, Senator Daschle's proposal (House Document 104-160), and the President's FY 1998 budget included provisions for removing these funds from the AAPCC. If these special payments were removed from plan payments, there should be some mechanism to ensure that managed-care plans, hospitals, and other organizations are paid for appropriate training activities.

In addition, the costs for any care Medicare patients receive that is not included in the claims data but that might be shifted to risk plans could be added to base rates. For example, the care beneficiaries get through the Departments of Veterans Affairs and Defense health care system is not reflected in the AAPCCs. The Prospective Payment Assessment Commission (ProPAC) has estimated that military and veterans' facilities provide care worth the equivalent of 3 percent of Medicare costs to beneficiaries nationwide (PPRC and ProPAC 1995). This share varies considerably across states, from a low of 1.2 percent in New Jersey to a high of 7.4 percent in South Dakota. The AAPCC would be a better estimate of likely care costs if it included the value of these services, to the extent that enrollees substitute managed-care services for them.

**Expand Geographic Basis of the AAPCC.** The use of broader geographic areas like metropolitan areas and nonmetropolitan parts of states would reduce both the variation in AAPCC-based rates and the volatility attributable to the small numbers of beneficiaries in some counties. Broader payment areas may also be more consistent with market areas served by risk plans. As discussed in last year's annual report, however, the small areas now used help compensate for the limitations of current risk adjusters, since there are some geographic patterns in health status (PPRC 1996). The use of larger areas, as proposed by the Senate last year, would reduce the extent of this implicit use of geography to capture differences in health status. Therefore, this approach would be most appropriate when coupled with an improved risk-adjustment scheme to ensure fair payments to plans.

### **Beyond the AAPCC**

The shift of beneficiaries from fee for service to the risk program is virtually certain to make the AAPCC increasingly unstable, reinforcing the view that the link between fee for service and risk payments should be severed. In fact, many alternatives have been proposed to do just that. There are two distinct types: those that build new payment rates from per capita fee-for-service spending, and those that discard the AAPCC altogether.

Payment alternatives that break the link between fee-for-service spending and managed-care rates change the relationship between the fee-for-service and risk programs with regard to Medicare per capita outlays, beneficiary costs, and beneficiary benefits. For example, if risk-plan payments were set higher than fee-for-service outlays in a particular county (as would happen if payment floors were implemented), Medicare would pay more for beneficiaries in risk plans than for those in fee for service. Presumably, beneficiaries would have more risk plans available locally. Conversely, if plan payments were reduced in some areas, Medicare would pay less for managed-care enrollees than for those in fee for service, and plans might increase premiums or decrease benefits. Recent congressional and Administration proposals have focused on changing risk-plan payments and have not considered the larger question of how fee-for-service Medicare and managed-care options compare on Medicare costs, beneficiary costs, and available benefits in different markets. Some have discussed broader reform that would more explicitly address the relationship between these two Medicare options, such as the federal premium contribution approach discussed in Chapter 9.

**Building Rates around the AAPCC.** Several approaches have been proposed to use the AAPCC as a basis for establishing more uniform payment rates nationwide. The different methods described below were included, in various combinations, in most of the Medicare reform proposals made in late 1995 and early 1996, as well as in the President's FY 1998 budget proposal. Most were also described in more detail in the Commission's 1996 annual report (PPRC 1996). If an AAPCC-based approach is used, the Commission recommends that the technical improvements described above should be made to the AAPCC. Further, it stresses the importance of analyzing the net effect of alternative proposals, which will depend partly on the order in which particular elements are introduced.

**Blended rates.** One way to reduce the geographic variation in AAPCC-based rates is to average the county-based AAPCC with a national price-adjusted per capita cost. This approach assumes that some degree of local fee-for-service variation in utilization is permissible because it reflects differences in health status or for other acceptable reasons. Otherwise, a simple price-adjusted national value would be appropriate. Inasmuch as acceptable variation differs across counties, different weights for blending the AAPCC and a price-adjusted national rate in different areas should be used. Most proposals include, however, a single national blend share. A market-specific blending approach could be easily implemented, as described later in this section.

Blended rates could be developed in two distinct ways. One approach is to calculate the AAPCC and national price adjusted rate each year and then take the appropriate weighted average. An alternative is to use the local and national rates from a base year, take their weighted average, and then adjust these base year rates annually for inflation. Under the first approach, the geographic variation in payments would evolve over time because of relative changes in fee-for service spending—changes that would not affect rates under the second approach.

Recent proposals all use the base-year approach, with future rates ultimately changing only through an update factor. The Balanced Budget Act of 1995, which was vetoed by the President, proposed an initial blend of 90 percent local AAPCC rates and 10 percent price-adjusted national rates; after a



four-year transition, the blend would be 70/30 by 2001. The blending would always be calculated from the AAPCC in the base year (1995). The Administration included a similar blending approach in its FY 1998 budget proposal. Once the final blend was reached, annual changes in payment rates would be the result of an explicit update.

Different local blends could be used instead of a set national share. These could be established based on the enrollment in managed care relative to that in fee for service in various markets, similar to an approach proposed by Rossiter and Adamache (1990). National and local rates could be blended to reflect the relative size of managed care and fee for service in local areas. The modification discussed here uses each year's AAPCC, rather than one from a base year updated over time, blending the AAPCC with updated local, rather than national, rates. Intuitively, this approach can be thought of as including per capita outlays for both risk enrollees and fee-for-service beneficiaries in the calculation of the coming year's capitation amount, or, in essence, the local Medicare per capita cost (MPCC).

Each year, local rates would be established as the weighted average of the prior year's payment rate, adjusted for inflation by, for example, the Medicare Economic Index (MEI), and the current year's AAPCC. The weights are determined by enrollment, with payments depending more heavily on the managed-care rate as managed-care enrollment rises. If fee-for-service costs outpace the managed-care rate, this weighting does two things. First, it generates higher payment growth in counties with rapidly rising fee-for-service costs or low managed-care enrollment. Consequently, plan participation and beneficiary enrollment should increase in those counties. Second, it reduces payments as managed-care enrollment grows, creating savings for the Medicare program.<sup>12</sup>

The implications of a simple version of this approach for actual payment levels can be easily simulated using 1995 and 1996 risk-program data. For 1996 and 1997, new local rates were calculated from the previous year's, updated by the weighted average of the value of the MEI (2.2 percent) and annual AAPCC changes. For these estimates, 1996 risk- and fee-for-service enrollment rates were used as weights. These calculations do not incorporate any feedback between changes in the payment level and the enrollment rate, an issue described in more detail later in this chapter.

These estimates suggest that such an approach would lead to an average payment of \$522 for risk enrollees in 1997, which is \$7 less than the average 1997 AAPCC-based payment for enrollees (Table 3-5). This difference would result in 1997 risk-program outlays of about \$312 million less than will occur under the AAPCC-based rates. Over time, the MPCC would diverge further from current rates if fee-for-service per capita costs grew more quickly than the measure of inflation used to update local rates.

---

<sup>12</sup> It may be appropriate to set risk-plan payment updates based on the lesser of the MEI (or other index) or fee-for-service cost growth. This approach would limit payment growth in the case that the MEI exceeded fee-for-service spending growth.

**Table 3-5. Comparison of Medicare Per Capita Cost (MPCC) Rates with Current Risk-Plan Payment Rates, 1996 and 1997**

	1996		1997	
	Current Rates	MPCC	Current Rates	MPCC
Mean Among Risk Enrollees	\$ 500	\$ 495	\$ 529	\$ 522
Mean Among Medicare Beneficiaries	441	441	468	466
Total Annual Risk Outlays (billions)	21.909	21.661	23.176	22.863

**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration published AAPCCs.

**NOTES:** Medicare per capita cost (MPCC) rates are the average of inflation-adjusted risk payment rates from the previous year with the present year's payment rate weighted by risk and fee-for-service enrollment shares, respectively. Current rates are calculated as 95 percent of each county's adjusted average per capita cost.

This basic approach could be enhanced by using local inflation rates to update the local base rate and by making some of the technical improvements described above to the AAPCC before calculating the MPCC. It might also be appropriate to use information about managed-care plan costs, similar to those collected in the ACR process, rather than payment amounts to calculate the MPCC. In addition, the approach could be used to blend a national risk-payment rate with local fee-for service spending, where the blend is set by the share of local beneficiaries in managed care versus fee for service.

**Trimming.** Trimming AAPCC-based rates through ceilings and floors would also result in less across-area payment differences. This approach accepts all fee-for-service per capita cost differences within the prescribed range but truncates those outside the range. The Balanced Budget Act of 1995 and the Daschle proposal from the 104th Congress both set minimum base rates, although at different levels. The Congress suggested floors of \$300 for 1996 and \$350 for 1997, compared with floors of \$310 for 1996 and \$325 for 1997 supported by the Administration. The President's recent budget proposal included a 1998 floor of \$350 or 150 percent of the 1997 rate, whichever is lower.<sup>13</sup> It might be appropriate to adjust thresholds for differences in local prices, although that was not included in any proposal.

**Updating Local Base Rates.** Blending and trimming approaches that use the AAPCC from a base year, updated with a national factor, may lead to idiosyncratic annual rate changes and will eventually lock in a particular pattern of geographic variation in payments. An alternative is to set policies depending on how payments change in different areas. Essentially another form of trimming rates, explicit update approaches either use the relationship of current local rates to the national average or set a minimum update. Under the first approach, local rates that differ from the national rate by more than some percentage are constrained so that they grow no more than a set amount. The reverse

<sup>13</sup> This second criterion was included because of extraordinary increases that would have occurred in a few counties under a simple \$350 floor.

applies for low base rates. The second approach sets some minimum increase for rates. It ensures at least some increase each year, which may not occur under current policy, blending, or trimming. It may also be appropriate to set a maximum rate increase.

Last year, the Congress included a minimum update provision to ensure that, after blending and trimming rates, counties received an update of at least 2 percent. The President's FY 1998 budget proposal maintains current rates for two years in order to protect counties from the reductions that will otherwise occur when earmarked funds are removed from the AAPCC base used in setting blended rates. After two years, a 2 percent minimum update is included. This minimum will offset some of the 5 percent reduction proposed to account for the cost of risk selection against traditional Medicare that will go into effect that year.

**Approaches Unrelated to the AAPCC.** Some methods for setting base rates are totally unrelated to the AAPCC. Under market-driven competitive approaches, rates are somehow established to reflect characteristics of local managed-care markets. The simplest such approach would be to set a national payment rate and then adjust it for differences in local prices. This method would not, however, capture other important differences in local health and managed-care markets. The Commission recommends that HCFA continue to test alternative methods such as competitive bidding, partial capitation, and reinsurance, which were discussed in prior reports (PPRC 1995; PPRC 1996). Competitive bidding was described in detail in the Commission's 1995 annual report and is the focus of a HCFA demonstration project (PPRC 1995). Implementation problems have delayed the start of the demonstration and led to a change in venue, from Baltimore to Denver. Another approach, which would affect both Medicare managed care and fee for service, is the introduction of a defined contribution system in Medicare. As described in Chapter 9, many of the same rate-setting issues would have to be addressed in designing such a system.

## **PAYMENT LEVELS AND THE GROWTH OF MEDICARE MANAGED CARE IN LOCAL MARKETS**

Current analyses of alternative risk-payment approaches are limited by the lack of information on how plans and beneficiaries react to changes in payment levels. As a result, analyses of alternative payment approaches are typically static, ignoring the market changes that may result from changes in policy. To improve understanding about these relationships, recent analyses of the Medicare risk program have focused on two key questions:

- How do managed-care plans decide whether to enter into Medicare risk contracts in individual markets and, when developing a risk contract, how do plans define their service areas within a particular market?
- Why do beneficiaries choose to switch from fee-for-service Medicare to a risk plan, and how do they choose among available plans?



These questions address distinct aspects of participation and enrollment, but are interrelated. For instance, beneficiaries' choices are clearly affected by how many and which plans have chosen to participate. It may also be the case, however, that plans' perceptions of why beneficiaries choose risk plans affect their decisions to enter markets or define particular service areas.

Understanding the role of payment policy factors in these decisions is essential to interpreting the likely effect of any policy change on risk-program growth. The rapid growth of the risk program and proposals for payment changes have raised the importance of these issues for policymakers. Unfortunately, researchers have only recently started focusing on these complicated questions.

Plan and beneficiary behavior are affected by other factors, some of which can be easily included in models but may be difficult to interpret. For example, the maturity of local managed-care markets, measured by the numbers of plans and commercial enrollment rates, is indicative not only of the supply side of the market but also of beneficiaries' familiarity with managed care. Other factors that may affect behavior are more difficult to include in models, such as Medicare's requirement that risk-plan service areas must be composed of contiguous counties and county parts.

### **Recent Studies of Responses to Risk Payment Changes**

Several recent studies have considered plan and beneficiary responses to different risk-plan payments. Besides the Commission's work, ProPAC has looked at these issues and developed models of plan decisions, while Welch (1996) modeled the beneficiary enrollment rate. This section briefly describes these models.

Previous Commission analyses reveal a high negative correlation between population size and volatility in local AAPCCs relative to the national average (Table 3-6). In addition, these analyses suggest that for a given level of the AAPCC and local population size, higher AAPCC volatility is associated with relatively lower risk-plan enrollment rates (PPRC 1995). This finding implies that regardless of the role that payment level plays in attracting plans and beneficiaries, changing payments will, in itself, reduce risk-plan participation. Increases in payments may, therefore, have a modest effect on risk-plan growth, at least in the short run. Inclusion of a measure of volatility in future models of these issues could provide estimates of the effect of payment changes net of the influence of volatility on behavior.

ProPAC models of plans' decisions to participate in the risk program and of service area definitions used metropolitan statistical areas (MSAs) as markets and commercial plan descriptions reported by the Group Health Association of America (GHAA). The decision whether to participate in Medicare is modeled with regard to Medicare's payment rate, characteristics of each plan, market and competitive conditions, and characteristics of area Medicare beneficiaries. ProPAC's estimates suggest that plans are highly sensitive to payment levels: a 10 percent difference in local rates is associated with an 11 percent higher probability that a plan enters that market. Since these estimates are based on a cross-sectional model and one year's data, they do not directly address the question of how plans in a particular market will react to changes in payment levels.

**Table 3-6. County Population, Payment Volatility, and Risk Enrollment Rate**

County Location	Average Number of Medicare Beneficiaries, 1995	Average Payment Volatility	Risk Enrollment Rate, 1995
Central Urban	175,819	1.8%	16.8
Other Urban	24,300	2.2	5.8
Rural Fringe	4,902	2.7	0.7
Other Rural	3,340	3.1	0.5

SOURCE: PPRC 1996.

NOTES: Payment volatility is measured as the annual average magnitude of change in a county's payment index for 1991 through 1995 as a percentage of its average index value for that time period. The payment index is the ratio of the county's payment rates to the national average rate per beneficiary.

Welch also used MSAs to define markets and the GHAA data about plans in his model of beneficiary risk-enrollment rates. His estimates suggest that Medicare's payment rate has a more modest effect on local risk-plan enrollment than the overall managed-care market share and Medicare's risk-program share five years earlier. Welch's model includes both supply (plan) and demand (beneficiary) factors and, as a partial-adjustment model, some time element. Unfortunately, because of differences in how results were reported, his findings cannot be directly compared with ProPAC's to isolate the likely magnitude of payment change responses.

ProPAC and Welch studied different questions and had different types of models. As a result, it is not surprising that they appear to have reached different conclusions about the sensitivity of actors to risk-plan payments. That ProPAC suggests plans are quite responsive to payment levels, while Welch implies the levels have a more modest effect on local enrollment rates, presents a puzzle to policy analysts trying to anticipate the effect of different rates on risk-program growth. Future research may help reconcile these findings and provide some consensus about what role Medicare's payment rate plays in plans' and beneficiaries' behavior.

### **Analyzing Plan Participation and Beneficiary Enrollment Decisions**

Analyzing Medicare managed-care markets and enrollment patterns requires information about the universe of plans available in a market as well as the features and enrollment rates of those plans participating in the risk program. Some important conceptual and data issues may, however, make it difficult to conduct such studies and complicate comparison of study findings.

**Unit of Analysis.** Plans presumably make choices about participating in Medicare's risk program based on the characteristics of local markets: the extent of competition, Medicare payment levels, provider supply, beneficiary characteristics, and local economic conditions like price levels. Plans' decisions to participate in the risk program are thus typically analyzed at the market levels, raising the difficult question of choosing the appropriate geographic boundaries of a market. This analytical

problem mirrors that of determining the geographic unit for which a Medicare payment rate should be set.

Managed-care markets are not well-defined, because the service areas of commercially available plans only partially overlap. In fact, plans that offer coverage through employers are available to people by virtue of where they work, regardless of where they live. Further complicating the notion of managed-care markets is that some plans—particularly group and staff model health maintenance organizations (HMOs)—serve enrollees through a limited number of facilities, while preferred provider organizations and independent practice association HMOs have many geographically dispersed offices. As a result, service area size may be correlated with type of plan, affecting the numbers and types of plans with overlapping service areas within a given market.

In practice, analysts' choices of market areas often reflect the availability of data on commercially available plans. Typically, these data are based on some notion of metropolitan areas. But some important details, such as whether primary metropolitan statistical areas (PMSAs) or consolidated metropolitan statistical areas (CMSAs) are used, sometimes must be simply inferred. For example, if southern California is represented as a single area, presumably the Los Angeles CMSA was used. Had PMSAs been the geographic basis, the data would have included separate cases for Los Angeles, Riverside, and Orange Counties.

In the context of the Medicare risk program, plans' service areas have a slightly different meaning and are better defined than in the commercial market. In their agreement with HCFA, plans describe, by county and county part (ZIP code), an area from which they will accept any Medicare beneficiary who applies. In this case, the service area is more definite and binding than in the commercial market. Even so, however, it is not clear how a market should be defined for analysis: it could be the union of all overlapping service areas, or the counties that fall within a metropolitan area. In fact, different definitions may be appropriate for considering different types of questions. For instance, the counties in a metropolitan area could be considered the universe of counties from which a plan chooses its commercial and Medicare service areas, but the union of risk-contract service areas could be the market for the beneficiary choice questions. In any case, such approaches overlook that different types of plans are likely to include different parts of the entire market in their service areas, which may become more important if Medicare broadens the types of plans offered to beneficiaries.

Some risk-program analyses have been conducted at the county level, reflecting the fact that payment levels are defined by county.<sup>14</sup> This approach uses all available Medicare data and bypasses the need to develop measures of county-level characteristics, such as payment rate, for larger areas. Such studies may mischaracterize or overlook across-county or market-level phenomena.

---

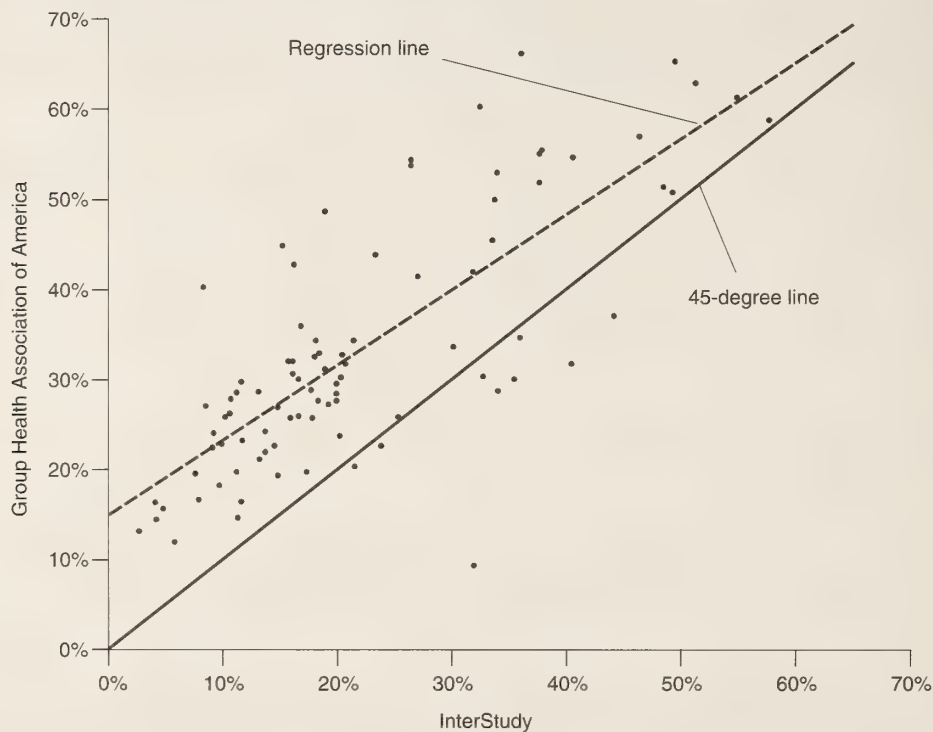
<sup>14</sup> Plans can define service areas based on ZIP codes, a fact that is typically not reflected in county-level analyses.



**Data Needs.** In addition to determining the relevant market area for analyzing plan behavior, studies of plan and beneficiary behavior also require information about commercially available plans, since these are the universe of potential risk-plan participants in each market area. Plans' commercial areas are the starting point for determining their Medicare service area, if they choose to participate in the risk program. It is difficult to find comprehensive data about all currently operating managed-care plans, however. Most analysts use GHAA and InterStudy as sources for these types of data.<sup>15</sup>

Despite important methodological differences between the two, analysts who need information about managed-care enrollment rates and characteristics of plans (e.g. plan type, years in operation, and service area) often assume information from one is comparable to the other. That is not the case. For instance, they report dramatically different rates of commercial enrollment in some of the 88 communities included in both sources in 1994 (Figure 3-1). These estimates suggest that among cities with very low enrollment rates, GHAA's estimates are systematically 15 percentage points higher than InterStudy's, with that difference diminishing as the enrollment rates rise.

**Figure 3-1. Comparison of Alternative Measures of HMO Penetration, 1994**



SOURCE: GHAA 1995 and InterStudy 1996.

NOTE: If the reported rates were roughly equal to one another, their relationship would be best described by the solid 45° line. Estimates from a simple linear model however, reveal that the best description of their relationship is given by the dashed line. The equation of the fitted line is: GHAA rate = .15 + .83 \* Interstudy rate, with an R<sup>2</sup> of 0.6.

<sup>15</sup> GHAA is now the American Association of Health Plans.

Given that analysts regard the two as different estimates of the same underlying phenomenon, the correlation between them is alarmingly low. In fact, in 7 of the 88 cases the reported managed-care enrollment rate for particular metropolitan areas differs by a factor of three or more.<sup>16</sup> These discrepancies suggest that differences in survey design and in area definitions and measures may be more important than is typically thought and thus may warrant closer analysis.<sup>17</sup> In any case, the differences between these two estimates are likely to affect analysis of the relationship between Medicare enrollment rates and these broader market rates. As a result, it may be important to consider the source of commercial plan data when interpreting and comparing estimates from studies of these broader questions.

## Policy Implications

Understanding how plans and beneficiaries react to payment changes is crucial to policymakers for anticipating the likely effect of payment policy changes. If, for example, plan and beneficiary behavior is relatively insensitive to risk-plan payment rates, then raising rates may not necessarily lead to more participation and dropping rates may not discourage it. Conversely, if plans and beneficiaries are extremely sensitive to base rates, then changes in rates are likely to result in greater participation in areas where rates increase and less participation where rates drop.

These behavioral responses have important implications for budget projections over a horizon longer than a year or two. In particular, developing strategies for budget-neutral implementation of payment changes is quite complicated, given the likely types of responses by plans and beneficiaries.<sup>18</sup> Budget projections should incorporate whatever information is available about plans' and beneficiaries' probable responses to payment changes. The studies by ProPAC and Welsh do not provide definitive guidance on how to include such responses in budget estimates. That these studies found other factors like overall managed-care penetration rates to have significant effects on risk-program participation, however, has important implications for the program's likely growth, regardless of payment policy changes.

Unlinking managed-care payments and fee-for-service spending will make it harder to project the Medicare budget accurately. By design, movement between managed care and fee for service by different types of beneficiaries under current policy should have no budget implications beyond the

---

<sup>16</sup> In six cases, the GHAA rate is three times the rate reported by InterStudy—such as in Ft. Lauderdale, Florida, where GHAA reports a managed-care enrollment rate of 40 percent, compared with InterStudy's 8 percent. In the seventh case, Gary, Indiana, InterStudy's reported rate of 32 percent is more than three times larger than GHAA's 9 percent.

<sup>17</sup> Any effort to describe managed-care plans in a given market requires decisions about how to categorize ownership/risk-bearing types and differentiate characteristics (such as enrollment and costs) of different products offered by a single plan. In the case of the 1994 GHAA and InterStudy data, the two also reflect different survey approaches, where GHAA used consumer surveys and InterStudy surveyed plans.

<sup>18</sup> If savings are to be generated by policy changes, these same issues apply to determining their magnitude.

5 percent reduction per beneficiary.<sup>19</sup> If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required to make accurate budget projections. In particular, it will be important to understand how beneficiaries in different risk categories select between managed care and fee for service. If risk payments are no longer set equal to fee-for-service spending, then the budget will be directly affected by the risk composition of the fee-for-service and risk-plan beneficiary groups. Outlays in the risk program will be determined by risk-enrollees' risk factors multiplied by the base rate; those in the fee-for-service program will be, roughly, fee-for-service beneficiaries' risk factors multiplied by the AAPCC.

If the base rate is no longer determined by the AAPCC, then movement of a beneficiary from fee for service to the risk program results in a change in total outlays. For example, if the AAPCC-based rate in a beneficiary's county were \$200 and the beneficiary's risk factor 1.2, then the beneficiary's expected fee-for-service outlays would be \$240 (plus 5 percent). If the beneficiary enrolled in the risk program, that plan would receive \$240. The beneficiary's switch into managed care thus would have led to a drop of \$240 (plus 5 percent) in fee-for-service-spending and an increase of \$240 in managed-care spending. If the county's base rate were raised to \$300, then the beneficiary's enrollment in a managed care plan would increase managed-care outlays by \$360 (the base rate multiplied by the risk factor). Thus, moving from fee for service to managed care would have increased total outlays by \$120, even though the base rate rose only \$100.

In sum, the budget effect of uncoupling base rates from fee-for-service spending is not simply the product of numbers of enrollees and the difference between the new rate and the AAPCC-based rate. Instead, it is the product of the average risk factor of enrollees, the number of enrollees, and the difference between the new base rate and the AAPCC-based rate. When new base rates exceed the AAPCC-based rate, total outlays will be larger than implied by the difference if risk plans attract less healthy beneficiaries. The enrollment in risk plans of low-risk beneficiaries would generate unexpected savings. Similarly, if new rates are lower than those based on the AAPCC, then selection against the risk program would yield lower-than-anticipated savings, while selection for the risk program would yield higher-than-anticipated savings.

This effect is due solely to the difference between the base rate and AAPCC, not to inadequate risk adjustment of payments across plans. Because there are no available analyses of the likely response to payment changes by beneficiaries by risk status, this issue cannot be reflected in budget projections. This issue would not arise under a defined contribution system, as discussed in Chapter 9.

---

<sup>19</sup> Contrary to this intent, there are, in fact, budget implications associated with migration of beneficiaries into managed care because of how current policies are implemented. These are due to limitations of current risk adjustment in setting the county base rate and in determining payments to plans, as described earlier in this chapter and in Chapter 4.



## REFERENCES

- Group Health Association of America, *Patterns in HMO Enrollment*, 4th edition (Washington, DC: June 1995).
- InterStudy, *The InterStudy Competitive Edge, Part III: Regional Market Analysis* (Minneapolis, MN: April 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Physician Payment Review Commission and Prospective Payment Assessment Commission, *Joint Report to the Congress on Medicare Managed Care* (Washington, DC: 1995).
- Rossiter, Louis, and Killard Adamache, "A Blended Sector Rate Adjustment for the Medicare AAPCC," *Journal of Risk and Insurance*, LVIII (2), June 1990.
- Welch, W. Pete, "Growth in HMO Share of the Medicare Market, 1989-1994," *Health Affairs* 15(3): 201-214, Fall 1996.



# Implementing Risk Adjustment in the Medicare Program

Risk selection and risk adjustment are becoming increasingly important issues as Medicare managed-care enrollment grows. Beneficiaries in managed-care plans are healthier than average, but Medicare's payment rates to these plans are based on the costs of the average fee-for-service beneficiary. Risk adjustment—paying more to care for ill beneficiaries and less for healthy ones—would reduce Medicare payments to plans, focus competition on value rather than on risk selection, and encourage plans to enroll people with costly medical problems.

Several risk-adjustment methods have been developed for use on the Medicare population. While the details of these approaches differ significantly, they all try to identify and pay more for beneficiaries in poor health. None is perfect, but implementing the best available methods would solve some of Medicare's risk-selection problems, and would recoup perhaps \$2 billion annually in excess payments to managed-care plans.

*The Health Care Financing Administration (HCFA) should adopt a new system for risk adjusting its payments to managed-care plans. As a first step, HCFA should immediately begin to phase in risk-adjusted rates by making modest payment changes using available Medicare administrative data and methods.*

*The Health Care Financing Administration should immediately enforce the existing requirement that hospitals report "no-pay" bills for hospitalized Medicare managed-care enrollees.*

*This chapter includes:*

- *Issues in risk selection and risk adjustment for Medicare*
- *Risk adjustment using diagnosis information*
- *Risk adjustment using survey data*
- *Phasing in risk adjustment using existing Medicare data*

## *Recommendations*



*Over the longer term, the data and infrastructure required to support risk adjustment based on the best available methods should be defined, developed, and implemented.*

*The Health Care Financing Administration should adopt data reporting requirements consistent with the needs of the new risk-adjustment system. These should include information on individual beneficiaries' diagnoses.*

*The Health Care Financing Administration should establish an orderly phase-in for all components of the risk-adjustment system, including data reporting, further development of risk-adjustment models, and implementation of adjusted payment rates.*

*During the phase-in of risk adjustment, changes in plan payment rates should be limited to protect plans and the beneficiaries they serve from sharp swings in payment.*

The key practical issue for risk adjustment in Medicare is obtaining the data needed to set payment rates. In order to pay higher rates for those in poor health, the Health Care Financing Administration must have information about beneficiaries' health status or their medical problems. Comparable information for both managed-care and fee-for-service beneficiaries is needed and must be reported in a way that permits auditing when necessary.

Implementing fully effective risk-adjustment methods in the Medicare program will take years, because the necessary data are not available. Nonetheless, certain steps can be taken now to begin the process of risk adjustment while developing the data reporting capabilities needed for making the adjustments more accurate.

Information on beneficiaries' diagnoses would provide the most stable basis for risk adjustment. Diagnosis-based risk adjustment works by identifying beneficiaries with costly conditions, like heart disease or cancer. Medicare already has this information on all fee-for-service beneficiaries, because it is routinely reported on Medicare claims. Managed-care plans could report either encounter data similar to Medicare fee-for-service claims, or a summary of each beneficiary's diagnoses. The ability of plans to report such data is discussed in Chapter 8.

An alternative way to gather data for risk adjustment is by surveying beneficiaries about their health status, functional disabilities, and chronic conditions. Payment rates based on surveys would be less stable and more difficult to audit than rates based on diagnosis data. Information gathered through surveys is useful, however, for identifying beneficiaries with high health care needs, and could be collected now while waiting for the capabilities and systems for diagnosis reporting to be developed.

Surveys could be used to make some partial adjustment of rates that would not only capture the overall degree of selection but would also reflect some variation in risk selection across plans.

In the short run, current Medicare administrative data could be used to make two different types of approximate adjustments in payment rates. Medicare might pay lower rates for new managed-care enrollees, based on solid evidence that they typically have low costs prior to enrollment. Medicare might also reduce some of the county-to-county variation in payment rates by applying risk-adjustment methods to the fee-for-service claims used to establish the base payment rates in each county. Even though existing data are far from ideal for risk-adjustment purposes, it is preferable to use them to move plan payments closer to true risk-adjusted rates, rather than waiting for better data or making an across-the-board payment reduction.

Little is known about the impact that improved risk adjustment and other proposed payment changes will have on managed-care plans. To avoid disruptions in the managed-care program, the size of the payment reductions in any year should be limited, and access to care within plans should be monitored (see Chapter 6). A reasonable strategy for smoothing the transition to risk-adjusted rates is to begin modifying payment rates using the most readily available data, then moving to fully-adjusted rates as the data for accurate risk adjustment are collected.

The first section of this chapter provides a brief overview of issues related to risk selection and risk adjustment. The next section outlines practical steps Medicare could take now to prepare for risk adjustment using diagnosis data. Survey-based methods for gathering data are discussed in the third section. The fourth examines how currently available administrative data could be used to begin making payment changes among plans and geographic areas. The chapter concludes by offering suggestions for phasing in risk-adjusted payment rates.

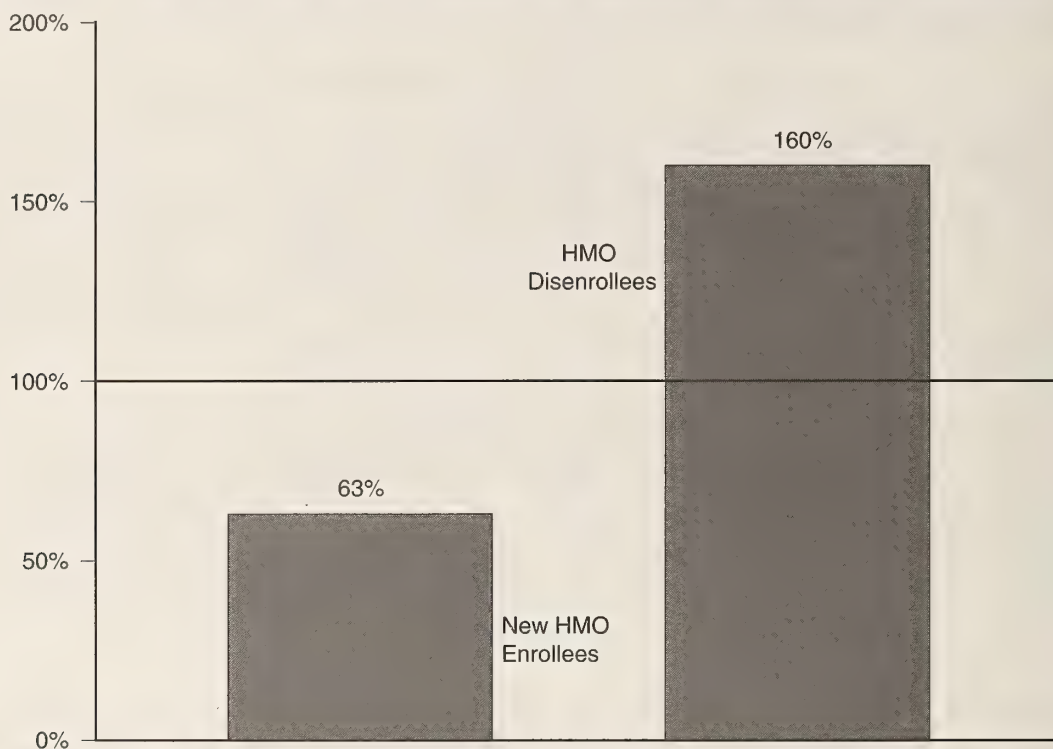
## **ISSUES IN RISK SELECTION AND RISK ADJUSTMENT FOR MEDICARE**

In last year's annual report, the Physician Payment Review Commission presented evidence of significant risk selection in the Medicare managed-care program (PPRC 1996). For the six months before enrolling in managed-care plans, beneficiaries' costs were 37 percent below those of a fee-for-service comparison group.<sup>1</sup> In the six months after disenrolling, beneficiaries costs were 60 percent above the fee-for-service average (Figure 4-1). On average, Medicare beneficiaries in managed-care plans are healthier and have fewer chronic conditions than those in the fee-for-service program (Riley et al. 1996).

---

<sup>1</sup> Research by HCFA staff and others has repeatedly demonstrated that the beneficiaries enrolling in managed-care plans have low costs. That research is summarized in Chapter 15 of the Commission's 1996 annual report (PPRC 1996).

**Figure 4-1. Costs as a Percentage of Average Medicare Spending per Beneficiary**



SOURCE: Physician Payment Review Commission analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample.

The causes of this risk selection are complex and may reflect actions of beneficiaries and health plans alike. It has long been suggested that healthy people have little preference for any particular physician and thus are more willing to switch into a managed-care plan (Berki and Ashcraft 1980). This tendency would make Medicare managed-care enrollees healthier than average, at least in the short term. For plans, the financial factors that drive managed-care efficiency also create incentives for selection. Under capitation arrangements, plans can profit by providing care more efficiently and by attracting beneficiaries who require less care (Newhouse 1996).

HCFA's rules governing managed-care plans are designed to protect beneficiaries and to prevent overt discrimination against those in poor health. Beneficiaries may enroll in or disenroll from managed-care plans on a monthly basis. They also have the right to formal grievance procedures if they believe they have been unfairly denied services or reimbursement for care. Managed-care plans cannot screen beneficiaries for health risks before they enroll and must charge all beneficiaries the same premium. In addition, all of their marketing materials must be approved by HCFA.



The overall effect of these rules on risk selection is not clear. Some of them, such as the ban on pre-enrollment health screening, probably decrease risk selection. Others, such as the monthly option to enroll or disenroll, may increase it.

### **Problems Caused by Inadequate Risk Adjustment**

The goal of HCFA's managed-care payment policy is simple: when beneficiaries enroll in managed-care plans, HCFA tries to pay plans the amount that it would otherwise have spent on those beneficiaries' health care.<sup>2</sup> HCFA aims to be financially neutral about beneficiaries' choices, paying the same amount regardless of which type of care beneficiaries choose.

Achieving that goal requires risk adjustment, and HCFA's managed-care payment formula has always contained a simple risk adjustment method based on demographic information. Each county's payment rate is based on the average cost of fee-for-service Medicare in that county, but plans receive different rates based on the demographics of their own enrollees. A plan enrolling older beneficiaries, for example, receives a slightly higher payment since fee-for-service Medicare's costs rise with the beneficiary's age.

HCFA's payment formula does a poor job of risk adjustment because the information available for setting payment rates is inadequate. HCFA sets payment rates using the demographic and other information routinely recorded for managed-care enrollees. Beneficiaries' age and gender, however, provide little information about their health, and explain only 1 percent of the variation in beneficiaries' health care costs.<sup>3</sup> Moreover, demographic differences do not account for managed-care enrollees' low costs prior to enrollment, or for their significantly better health status (PPRC 1996; Riley et al. 1996).

The lack of adequate risk adjustment causes a wide range of problems for Medicare's managed-care program. These problems can be viewed from three perspectives: the Medicare program, individual managed-care plans, or beneficiaries.

From the Medicare program's standpoint, the lack of adequate risk adjustment increases spending. Medicare's capitation payment in any county is based on the costs of the average fee-for-service beneficiary in that county. When a managed-care plan attracts beneficiaries whose health is above average, program spending is increased in two ways. Medicare pays plans perhaps \$2 billion more annually than it would have if plan payments were risk adjusted.<sup>4</sup> In addition, the county-level capitation rates are inflated because they are based on the sicker beneficiaries who stay in the fee-for-

---

<sup>2</sup> Medicare reduces that amount by 5 percent for program savings.

<sup>3</sup> See, for example, Ellis et al. 1996.

<sup>4</sup> Recent HCFA research projected managed-care enrollees' costs at 12 percent to 14 percent below average, even after adjusting for their demographics (Riley et al. 1996). Because that figure was based on the Medicare Current Beneficiary Survey, it is effectively an estimate of the change in payments that would result from survey-based risk adjustment. Applying that reduction to current Medicare payments to risk plans would result in roughly \$2 billion in program savings.

service program. Removing this bias in the county rates would additionally reduce annual Medicare outlays by several hundred million dollars (GAO 1997).

As for managed-care plans, inadequate risk adjustment affects both profits and competition. Ideally, plans that can deliver high-value care efficiently gain market share at the expense of others. But risk selection causes windfall gains and losses: an efficient plan burdened with costly beneficiaries may not be able to compete, whereas an inefficient plan that attracts healthy ones may increase market share. Available evidence, though scarce, suggests that risk selection may vary substantially across plans. Risk selection distorts the value signals that the market should provide, and may focus competition on selection rather than on value.

Finally, from the beneficiary's standpoint, the lack of adequate risk adjustment may affect access to care for those with high-cost conditions. Plans may be reluctant to invest in facilities and personnel for treating these beneficiaries because of the potential for significant financial losses. This could result in underinvestment in care for the chronically ill and barriers to access for those beneficiaries (see Chapter 5).

### **Prior Commission Work on Risk Adjustment**

The Commission's work last year clarified some of the issues around risk adjustment in Medicare (PPRC 1996). First, identifying the best possible risk-adjustment model is not critical: several methods using either diagnosis or survey data appear to work fairly well in predicting costs.<sup>5</sup> Second, reinsurance or partial capitation methods are not, practically speaking, a substitute for risk adjustment.<sup>6</sup> To perform as well as the best risk-adjustment methods at reducing overpayments to plans, reinsurance and partial capitation would require making a very large portion of payments to plans on a fee-for-service basis (PPRC 1996). Those approaches might best be used in conjunction with another risk-adjustment method.

Risk-adjustment methods appear to do reasonably well at predicting the costs of groups of Medicare managed-care enrollees. In particular, the Commission found that diagnosis-based risk adjusters would account for about half of the low costs of new managed-care enrollees (PPRC 1996).<sup>7</sup> Accuracy is good when predicting the costs of groups of beneficiaries having a particular chronic condition or level of health status (Ellis et al. 1996).

---

<sup>5</sup> Since the publication of last year's report, a newer diagnosis-based method (hierarchical coexisting conditions) has been developed that may offer somewhat better explanatory power than older diagnosis-based methods (Ellis et al. 1996).

<sup>6</sup> Reinsurance would pay plans on a (possibly reduced) fee-for-service basis for beneficiaries whose costs exceeded some threshold, for example, \$10,000. Partial capitation would pay plans both a reduced capitation amount per beneficiary and a reduced fee per service.

<sup>7</sup> That is, if new enrollees' costs were 30 percent below average in the year prior to enrollment, the diagnosis-based risk adjusters would have set capitation payments for those enrollees at 15 percent below average.

Risk-adjustment methods are better at predicting costs for groups than for individuals, in part because so much of the variation in individuals' costs is truly random. Even so, risk-adjustment methods capture, at best, perhaps a third of the nonrandom variation in costs among individuals (Newhouse 1994). That may leave a significant financial incentive to try to select some persons even when the best risk-adjustment methods have been applied to payments (Newhouse 1994).

Using the best available risk-adjustment methods would solve some (but not all) of the problems caused by risk selection. Payment for groups of beneficiaries would move significantly toward an ideal risk-adjusted rate, and the incentives to select good risks would be reduced. But risk-adjustment methods underpredict the variation in costs across individuals and groups, and consequently result in underadjusted payment rates. Not even the best risk adjustment methods will completely adjust payments or eliminate all incentives for selection, and risk adjustment might ideally be combined with other methods to limit risk selection.<sup>8</sup>

### **Data for Risk Adjustment**

The primary practical barrier to improved risk adjustment in the Medicare program is data. Adjusting payment requires information on the health or diagnoses of beneficiaries in both fee-for-service Medicare and in managed-care plans. The need for equivalent data from both parts of the Medicare program is a technical issue requiring some explanation.

Risk adjustment is done in two steps: estimation and calculation. Medicare fee-for-service data are used to estimate the relationship between beneficiaries' characteristics and their health care costs. That can be as simple as placing beneficiaries into groups and then calculating the average health care costs in each group. For example, data might show that beneficiaries in poor health cost, on average, \$10,000, that those in good health cost \$5,000, and that those in excellent health cost \$2,500.<sup>9</sup> More sophisticated methods can be used to account for several characteristics simultaneously (for example, health status and presence of chronic illnesses).

Once that is done, the estimated relationship between health and costs is used to calculate plans' payment rates based on the characteristics of their enrollees. Continuing the example above, a managed-care plan would receive \$10,000 for each beneficiary in poor health, \$5,000 for each one in good health, and \$2,500 for each one in excellent health.

To make these payments, though, Medicare needs data on the risk factors of the beneficiaries in each managed-care plan. There are three different types of data that Medicare could use to improve risk

---

<sup>8</sup> See Chapter 4 of the Commission's 1996 annual report for recommendations on ways to improve Medicare's managed-care enrollment process (PPRC 1996).

<sup>9</sup> Or, alternatively, beneficiaries with cancer cost \$10,000, those with high blood pressure cost \$5,000, and those with no chronic conditions cost \$2,500.



adjustment. HCFA could set payment rates using diagnosis information as reported in encounter data or claims, self-reported health status as captured by surveys, or available administrative data.

## **RISK ADJUSTMENT USING DIAGNOSIS DATA**

This section looks at the practical steps needed to set risk-adjusted payment rates using diagnosis data. Encounter data would provide the most reliable source of diagnosis information. Encounter data would be similar to Medicare's fee-for-service claims, with diagnoses and other information reported each time a beneficiary used the health care system. But requiring the reporting of encounter data would impose significant costs on both plans and the Medicare program. Alternatively, an annual summary of each beneficiary's diagnoses might provide enough information for risk adjusting payment rates. While summaries might be easier for plans to provide, they would be more difficult to audit, might not be comparable to Medicare fee-for-service diagnosis information, and would not be useful for examining either access or quality of care.

The first part of this section describes diagnosis-based risk adjustment. The second part discusses the advantages and disadvantages of this approach. Finally, ways to obtain and audit diagnosis data are presented.

### **Methods of Risk Adjustment Using Diagnosis Information**

HCFA's Office of Research and Demonstrations (ORD) has funded development of a variety of risk-adjustment methods based on beneficiaries' diagnoses. These include diagnostic cost groups (DCGs), ambulatory care groups (ACGs), and, more recently, hierarchical coexisting conditions (HCCs).

Although details differ significantly, all of these methods follow the same basic approach. They identify diseases that are costly to treat, and use diagnosis information from Medicare claims to group beneficiaries according to disease. Some care is taken to see that more severe disease takes precedence over more modest manifestations of the disease.<sup>10</sup> The methods were developed to be neutral with respect to patterns of care, so that patients are not moved into higher cost groups solely because they received more extensive treatment. Some models do, however, take into account certain high-cost procedures for which physicians are apt to have little discretion in determining use of the procedure.<sup>11</sup>

Two approaches (DCGs and ACGs) were originally designed to put each beneficiary into a single category based on the beneficiary's highest-cost diagnosis, but this constraint was dropped in later versions. The HCC model was designed from the outset to reflect numerous diagnoses simultaneously,

---

<sup>10</sup> For example, a beneficiary with diagnoses for an early stage and a later stage of cancer would be placed into the diagnosis group for later-stage cancer only, not into groups for both early- and later-stage cancer.

<sup>11</sup> For example, some versions of HCCs take into account such procedures as major organ transplant, major amputation, dialysis, and ventilator dependence in setting payment rates (Ellis et al. 1996).

and appears to perform significantly better at predicting costs than the other two approaches (Ellis et al. 1996).

To use these models to set risk-adjusted payment rates, HCFA would use its existing fee-for-service claims data to estimate the payment amount for each diagnosis group. HCFA would have to require managed-care plans to report diagnosis information for all enrollees. On the basis of this information, HCFA would assign each managed-care beneficiary to the relevant diagnosis group or groups, then calculate each plan's payments accordingly.

### **Advantages and Disadvantages of Diagnosis-Based Risk Adjustment**

A diagnosis-based approach to risk adjustment would have several important advantages. First, these methods would capture a significant portion of the risk selection among groups of beneficiaries (Ellis et al. 1996). ACGs or DCGs, for example, accounted for half of new managed-care enrollees' low costs prior to enrollment (PPRC 1996).

Second, these methods would produce stable payment rates because they use information from all beneficiaries. For fee-for-service beneficiaries, the Medicare program already routinely collects diagnosis information. That information would allow HCFA to estimate its payment rates for each diagnosis group using the cost experience of the entire fee-for-service program, and would allow HCFA to set accurate payments even for diseases affecting just a small proportion of Medicare beneficiaries. For managed-care beneficiaries, requiring diagnosis information for all enrollees would avoid the statistical uncertainties that would arise if data were available for only a sample of beneficiaries.

Third, these approaches could easily be integrated into HCFA's existing method for setting risk-plan payments. As explained later in this chapter, any risk-adjustment method that HCFA uses will be applied twice: once to Medicare's own fee-for-service data in each county, and once to the data from each managed-care plan. Because the diagnosis-based methods can be applied directly to existing Medicare fee-for-service claims, calculating a diagnosis-based adjustment for the Medicare fee-for-service data in each county is straightforward.

The main drawback to this approach is that it would require a substantial new data collection effort. Managed-care plans are not now required to submit encounter data, and doing so is a controversial and expensive proposition (see Chapter 8). It may take several years for HCFA and managed-care plans to develop the capability to report such diagnosis data in any form. Beyond that, HCFA may need several more years to verify the completeness and accuracy of the data reported.

A secondary drawback is that diagnosis-based risk adjustment does not account well for beneficiaries' functional limitations. For example, a diagnosis of congestive heart failure does not differentiate beneficiaries who are bedridden or housebound from those who have no such restrictions on their activities. As discussed in Chapter 5, functional and general health status measures may account for some systematic differences in health care needs that are not captured by diagnoses alone.

## Obtaining Diagnosis Data

On balance, the benefits of improving payment rates with diagnosis-based risk adjustment merit overcoming the problems with collecting diagnosis information. These benefits led the Commission to recommend starting the development of the infrastructure necessary to collect diagnosis data on all beneficiaries, and adopting the requirement that managed-care plans report diagnosis information on each enrolled beneficiary.

Obtaining diagnosis data from managed-care plans requires answering three basic questions. First, how will the data be reported, as encounter data showing each individual service provided to beneficiaries, or as a summary of each beneficiary's diagnoses? Second, how will HCFA give plans a financial incentive to report data? Finally, how will HCFA audit the data to ensure that the reporting is accurate and that the resulting payment rates are correct?

**Encounter versus Summary Data.** Diagnosis information could be reported by managed-care plans either as encounter data or as an annual summary of each beneficiary's diagnoses. Under the encounter data approach, each office visit, hospitalization, or procedure would be reported electronically to HCFA, providing a stream of data throughout the year similar to Medicare fee-for-service claims.

Encounter data have several advantages. Encounter files could be run through the same editing and auditing software that Medicare applies to its fee-for-service claims files, guaranteeing the greatest degree of comparability between Medicare fee-for-service and managed-care data. These data could also be used to monitor access and quality of care, using algorithms that check for the provision of services that physicians judge to be necessary in the treatment of specific diseases or conditions (Ash et al. 1995). The disadvantage is that requiring submission of encounter data would place a significant reporting burden on plans and providers, and it may be difficult to enforce a requirement that plans report data in this form.<sup>12</sup>

Alternatively, HCFA could require an annual summary of each beneficiary's diagnoses.<sup>13</sup> These data may be easier for plans to report. While most diagnosis-based risk-adjustment models can use such information, these data would be more difficult to audit because HCFA would not know where and when any particular diagnosis was recorded. HCFA would also be less able to check for comparability against its fee-for-service claims. Finally, a summary file would not be useful for monitoring of quality and access or examination of patterns of care.

---

<sup>12</sup> Technically, as discussed in Chapter 8, plans will need to develop the capability to record and report such information. In addition, providers may be reluctant to submit encounter data for business reasons: encounter data might affect negotiations between plans and subcapitated providers because it would reveal the amount of services provided.

<sup>13</sup> The summary file must have separate information on each beneficiary, not an aggregate count of beneficiaries with particular diagnoses. The best risk-adjustment models depend on the presence or absence of multiple diagnoses (comorbidities) for each beneficiary. In addition, aggregate counts probably could not be audited by HCFA, while data on individual beneficiaries could be checked against medical records if necessary.



**Financial Incentives for Submission of Data.** Because submission of diagnosis data could lead to reduction in the payment to a plan, HCFA would need to create some financial incentive for plans to submit data. To create an incentive, the penalty for failing to report data would have to be larger than the payment reduction that would occur when the plan reported the data. Yet, HCFA could not set penalties that were so large that they disrupted the existing managed-care program.

One option would be to make submission of data a condition of participation in the program. Plans unable or unwilling to submit diagnosis data could not be offered to Medicare beneficiaries. While such an approach might work for new plans and smaller plans, it probably could not be enforced on plans that currently serve a large number of beneficiaries because failure to renew a managed-care contract would disrupt health care delivery for those beneficiaries. Thus, this approach could best be applied to new risk contracts, not to Medicare's existing managed-care plans.

A second approach would be for Medicare to assume that all beneficiaries fell into the lowest-cost category in the risk-adjustment method until notified otherwise. This assumption would simplify HCFA's operational tasks: plans that did not submit data would be paid as if all beneficiaries were healthy. This approach would result in very low payment rates for nonreporting plans. Again, this method might be applied to new risk contracts, but might not be enforceable for large existing plans.

A third option would be to pay nonreporting plans at a significant discount to their competitors' payment rates. For example, payment rates for nonreporting plans in a market area could be set at 10 percent below the lowest rate paid to any plan reporting data. This would create an incentive for nearly all plans to report data, but would still set payments at a credible level for plans failing to report data. This approach might be applied to both new and existing plans.

Finally, these approaches could be coupled with a policy of paying plans to submit data (Welch 1995). A reduction in the average payment rate for all plans would provide funds that would be used to pay for data from managed-care plans on a per-encounter basis. Plans that did not report data would lose these payments.

**Auditing Data for Accuracy.** A third critical element in implementing diagnosis-based risk adjustment is a method to check the accuracy of the diagnosis data submitted by plans. Checking diagnosis data against medical records would be costly for HCFA and for managed-care plans alike. HCFA could, however, use existing data both to provide an initial check on plan data submissions and to flag selected plans for more intensive audit efforts.

First, for a significant percentage of managed-care enrollees, Medicare could develop historical diagnosis profiles using claims from the period prior to enrollment.<sup>14</sup> Currently, roughly 55 percent of managed-care enrollees have been enrolled in plans three years or fewer (see next section).

---

<sup>14</sup> HCFA already has some of this work under way, collecting the fee-for-service claims of all beneficiaries who join managed-care plans.

Commission analysis of enrollment data shows that nearly 90 percent of these enrollees had had some experience in fee-for-service Medicare before joining a managed-care plan. (The remainder were already enrolled in managed-care plans when they turned 65 or otherwise qualified for Medicare.) For new enrollees, these historical profiles could be compared to data reported by managed-care plans. Large changes in the diagnosis profiles over a short period of time would signal reporting differences between local fee-for-service providers and the managed-care plan. More intensive audits would focus on plans with the largest changes in the diagnosis profiles of the new enrollees.

Second, so-called no-pay hospital bills could provide another information source for monitoring data reporting from plans. Hospitals are required to submit bills to HCFA for hospitalized managed-care beneficiaries, even though HCFA does not pay them for these cases. In practice, though, fewer than half such bills appear to be processed (GAO 1991). There appear to be few technical barriers to obtaining complete data, but because hospitals have no financial incentive to produce such no-pay bills, it is difficult to enforce this regulation.

In the absence of risk adjustment, it may not have been worthwhile to obtain these data. Now, however, these data may be used to provide a critical check on data reporting and risk adjustment. The Commission recommends that HCFA take the steps necessary to obtain these data. Doing so may require paying the hospitals for the bills, or instituting much more aggressive enforcement of the requirements.<sup>15</sup> This issue is discussed more thoroughly in Chapter 8.

## **RISK ADJUSTMENT USING SURVEY DATA**

The principal alternative to diagnosis data is information from surveys of Medicare beneficiaries. A survey could gather information on risk factors that affect health care use, such as overall health status or disability. The Medicare program could gather such information now, without waiting for plans to report diagnosis data.

Payment rates based on responses to surveys are likely to be less reliable than those calculated from diagnosis data. Survey-based rates would reflect risk selection, but would also be affected by misreporting and random error. Because of this, caution is necessary in using survey data for payment purposes, and payments would at best be moved part-way between current levels and the risk-adjusted rates calculated from survey data.

The first part of this section briefly describes the survey-based approach. The next part examines advantages and disadvantages of survey-based risk adjustment. Two ongoing HCFA surveys that could be used for risk adjustment are then described.

---

<sup>15</sup> If medical education payments were removed from the Medicare capitation rates and paid to hospitals directly, hospitals would have to file no-pay bills to collect these payments.

## **Description of Survey-Based Risk Adjustment**

Survey-based approaches to risk adjustment begin from the observation that beneficiaries who report feeling in poorer health, having more limitations due to disability, and having more chronic conditions can be expected to have higher health care costs. Using surveys to adjust Medicare payments would require a series of steps.

First, the survey would be administered to a large sample of fee-for-service beneficiaries. Responses to the fee-for-service portion of the survey would be used to estimate the payment rates for the various risk factors. For example, results might show that Medicare fee-for-service beneficiaries reporting themselves to be in poor health cost the Medicare program \$5,000 per year more than beneficiaries reporting themselves in good health. This sample needs to be quite large to get accurate estimates of the impact of the risk factors on cost.

Second, survey-based risk adjustment would require surveying a sample of beneficiaries in each managed-care plan. The responses to this survey would be used to calculate each plan's payment rate. For example, if 5 percent of those answering the survey from a particular plan reported themselves in poor health, then the plan's payment rate would be calculated as if 5 percent of its entire population was in poor health.

## **Evaluation of Survey-Based Risk Adjustment**

Risk-adjustment models using survey data appear to work about as well as models using diagnosis data for predicting individual beneficiaries' costs (Park Nicollet 1994).<sup>16</sup> Although surveys cannot provide clinically precise diagnosis information, they can collect data on general health status and functional limitations. This information is helpful for identifying some patients with high health care needs (see Chapter 5).

The main practical advantage of survey-based risk adjustment is that the Medicare program can gather the information now, and need not wait for diagnosis data to become available. If HCFA were not able to obtain diagnosis data, surveys would become one of the few available tools for gathering comparable information on fee-for-service and managed-care beneficiaries.

A second advantage is that surveys offer the potential for obtaining information of exactly the same type and form from both the fee-for-service and managed-care segments of Medicare. The diagnosis information reported by managed-care plans may or may not be strictly comparable to what is currently reported on Medicare fee-for-service claims. Fee-for-service physicians, for example, have no

---

<sup>16</sup> This conclusion is based on the ACG and DCG diagnosis-based approaches. There has been no direct comparison of the newer HCC diagnosis-based method to survey-based approaches. Research suggests, however, that the HCC approach may perform somewhat better than the older diagnosis-based methods (Ellis et al. 1996).



financial incentive to report diagnosis information accurately. Surveys, by contrast, would impose a uniform reporting system on all parts of the Medicare program.

The main drawback to surveys is that the resulting payment rates may be imprecise and subject to many types of error. Unlike diagnosis data which could be made available for all beneficiaries, survey data would be available only for a sample of beneficiaries, and within that sample, only for those willing to answer the survey. Payment rates to individual plans would embody some random element because only a sample of beneficiaries would be surveyed. Furthermore, these rates potentially would be subject to biases from beneficiaries' unwillingness to answer the survey or from plans' ability to influence beneficiaries' answers.<sup>17</sup> In addition, the payment formula itself would be estimated from the experience of a relatively small sample of fee-for-service beneficiaries, resulting in uncertainty in the payment rate associated with any particular chronic condition or level of health status.

A second drawback to the survey-based approach is that survey data are difficult to audit. Surveys record how beneficiaries feel about their health and the conditions they believe they have. There is no objective standard against which to compare this information.

A third disadvantage of surveys is the difficulty integrating survey-based risk adjusters into Medicare's current method for setting capitation payments. As discussed later in this chapter, current practice requires calculating a risk-adjustment factor for the fee-for-service population in each county. That can be done from existing claims data for the diagnosis-based risk adjusters. For survey-based methods, matching current practice would in theory require surveying the fee-for-service population in each county, greatly increasing the costs and complexity of the survey.

Finally, survey-based risk adjustment requires surveying a large number of beneficiaries. Because Medicare must set rates for each managed-care plan, a separate sample of beneficiaries must be drawn from each plan. With more than 200 plans participating in Medicare, even a minimal sample of 1,000 beneficiaries from each plan would result in a very large sample size overall (200,000 beneficiaries).<sup>18</sup> Surveys of this size may be both costly and difficult to administer.

### **Obtaining Survey Data**

Two approaches for gathering survey data could be implemented immediately. First, the Medicare Current Beneficiary Survey (MCBS) could be expanded to include samples of beneficiaries in the largest managed-care plans. Second, a planned survey of the health of seniors in managed-care plans could be enlarged to include a significant sample of fee-for-service beneficiaries.

---

<sup>17</sup> Of these sources of error, only the statistical sampling error can be easily quantified. A rough estimate of the sampling error can be obtained by replicating a recent risk-adjustment analysis performed by HCFA staff (Riley et al. 1996). For modest sample sizes (1,000 beneficiaries, 80 percent response rate), payment rates would be in error by 6 percent or more for 1 plan in 20.

<sup>18</sup> As discussed below, however, just a handful of plans account for the majority of enrollment. A strategy of surveying beneficiaries in only the largest plans would partially solve this problem.

**Expanding the Medicare Current Beneficiary Survey.** The MCBS collects a broad range of information on roughly 16,000 beneficiaries, including data on general and functional health status and chronic conditions. This survey has been administered to Medicare beneficiaries since 1991. HCFA recently expanded the sample to include a larger number of managed-care enrollees.

The MCBS would provide a high-quality, tested method for gathering information for improved risk adjustment. First, the MCBS uses face-to-face interviews for gathering information, has a well-established survey protocol, and includes some redundant information. These features minimize problems of nonresponse bias and inaccuracy of responses. Second, since risk-adjustment models have already been estimated using MCBS data, a body of research would be immediately available to support calibration of a risk-adjustment model.

The main drawback of expanding the MCBS is cost. At present, the cost per beneficiary for such an expansion is estimated at \$350 per completed survey.<sup>19</sup> Surveying 1,000 beneficiaries in each managed-care plan (probably a minimum realistic sample size) would cost about \$350,000 per plan.

One way to minimize the expense of data collection would be to confine the survey to the largest managed-care plans. Medicare managed-care enrollment is highly concentrated, with 20 managed-care contracts accounting for about half of all Medicare managed-care enrollment (Table 4-1). Thus, for perhaps a \$7 million investment, Medicare could begin to address about half of its risk adjustment problem.

**Table 4-1. Concentration of HMO Enrollment in Medicare, 1996**

Largest Contracts	Percent of All Medicare HMO Enrollment
Top 10 Contracts	35%
Top 20 Contracts	48
Top 30 Contracts	57
Top 40 Contracts	61
Top 50 Contracts	70

SOURCE: Physician Payment Review Commission analysis of Enrollee Data Base file, 5 percent sample, January 1996.

**Risk Adjustment Using the Health of Seniors Survey.** In 1997, HCFA's Office of Managed Care (OMC) plans to oversee a large-scale survey of the health status of managed-care enrollees.<sup>20</sup> For a variety of reasons, information from this survey is not likely to be as reliable as that from the MCBS. Nevertheless, adding a fairly inexpensive sample of fee-for-service beneficiaries would make it possible to use the survey results for estimating some of the risk selection at the plan level.

<sup>19</sup> This is based on a conversation with the project director for the MCBS at Westat, the main contractor for the survey.

<sup>20</sup> This survey is part of the Health Plan Employer Data and Information Set (HEDIS) standards for monitoring quality of care in managed-care plans.

HCFA will conduct the survey on an annual basis. A vendor chosen by HCFA will administer a standard health status questionnaire (the SF-36) by mail to beneficiaries in managed-care plans, with a goal of obtaining 700 responses in each plan. OMC will use the survey to monitor quality of care in these plans.

The main advantages of this survey are its size and low cost. Data will be available for each of more than 200 managed-care plans that contract with Medicare. The cost will be roughly \$20 per completed survey.<sup>21</sup> Plans—rather than HCFA—will bear the cost of the survey.

This survey has several disadvantages, however. First, it lacks a systematic sample of fee-for-service beneficiaries. Responses from fee-for-service beneficiaries are needed to estimate the relationship between health status and costs. Without such data, it may not be possible to estimate payment rates using the survey. Second, a survey that is mailed is likely to provide much less reliable data than one conducted face-to-face like the MCBS. Finally, the survey was not designed for risk-adjustment purposes; the use of the SF-36 survey instrument and a sample of just 700 beneficiaries per plan may limit what can be done with the resulting information.<sup>22</sup>

Despite these drawbacks, the survey affords an opportunity to gather information on risk selection at a relatively modest cost. These data may or may not be reliable enough to be used to make significant changes in plan payment rates. At a minimum, though, the survey would provide some information on the average degree of risk selection in managed-care plans generally, and, potentially, on variation in risk selection across plans.

## **RISK ADJUSTMENT USING CURRENTLY AVAILABLE DATA**

Significant time and expense would be required to obtain either diagnosis information or survey data. Some adjustment in managed-care payment rates can be done now, however, using currently available Medicare administrative data. These data can be used to begin moving payment rates in the proper direction until more accurate risk adjustment can be implemented.

In the Commission's view, existing data should be used to improve upon current risk adjusters and would be preferable to a policy of an across-the-board reduction in payment rates such as that included in the Administration's recent budget proposal.<sup>23</sup> Currently, risk selection may vary significantly across plans, and Medicare's payment rates vary enormously across geographic areas. A uniform reduction in

---

<sup>21</sup> This cost estimate was supplied by HCFA OMC staff. It is a preliminary estimate and may change significantly once the survey is actually fielded.

<sup>22</sup> For example, compared with the MCBS, this survey does not gather much information on functional health status or the presence of chronic conditions, both of which are useful predictors of costs.

<sup>23</sup> The Administration's proposal includes a provision to reduce managed-care payment rates by about 5 percent beginning in the year 2000.



rates would create savings, but might increase incentives for risk selection while failing to make any payment distinctions among plans or across geographic areas.

In the short run, at least two different types of risk adjustments could be made using currently available data. First, somewhat lower rates could be paid for new managed-care enrollees, based on solid evidence of low use prior to enrollment. Second, Medicare could make some market-level (county-level) adjustments in its payment rates using its own fee-for-service data.

### **Paying Less for New Managed-Care Enrollees**

A wide variety of studies have demonstrated that Medicare managed-care enrollees have low costs before they join a managed-care plan. Last year, the Commission found that, for the six months prior to enrollment, new enrollees' costs were 63 percent of those of a fee-for-service comparison group (PPRC 1996). That estimate was roughly comparable to many earlier estimates.<sup>24</sup>

Other studies have suggested that costs for new enrollees rise slowly once enrolled in a managed-care plan, a phenomenon termed regression toward the mean (Welch 1985). The Commission found that new enrollees' hospitalization and mortality rates increased during at least the first five years of managed-care enrollment (PPRC 1996).<sup>25</sup> Others have shown steadily increasing mortality rates the longer a beneficiary is enrolled in a plan, and have studied regression toward the mean for cohorts of Medicare beneficiaries (Riley et al. 1989; GAO 1997).

These two factors—low costs before enrollment and slowly increasing costs over time—suggest that plans having a high proportion of new enrollees may have significantly lower costs than do older, more established plans. This difference among plans could be addressed by an interim risk-adjustment method that pays less for new managed-care enrollees but allows payment rates to rise as enrollment tenure lengthens. Plans whose enrollment consists largely of new enrollees would be paid less, while those with more stable enrollment would be paid more. This approach is preferable to an across-the-board reduction in rates, which would fail to account for these differences among plans.

A number of important technical questions would have to be answered before implementing such a policy, and there is relatively little research to guide the use of this technique for risk adjustment (Wrightson et al. 1996; GAO 1997). Decisions would be required on the size of the payment reduction, how long that reduction would be in place, and what reduction (if any) would be made for beneficiaries who were enrolled in a managed-care plan before their Medicare enrollment.

Paying less for new enrollees could significantly affect payment rates, since new enrollees make up a large portion of total enrollment. The rapid expansion of Medicare managed care has resulted in an increase in that proportion in the past few years. In 1993, for example, about 43 percent of Medicare

---

<sup>24</sup> This research is summarized in Chapter 15 of the Commission's 1996 annual report (PPRC 1996).

<sup>25</sup> All these are age-adjusted rates. Thus, this is not the effect of aging, but is the pure effect of length of enrollment.

managed-care enrollees had been enrolled for three years or less. By 1996, that figure had climbed to 55 percent of managed-care enrollees (Table 4-2). Individual plans vary significantly in the makeup of their enrollment, with some plans having many more long-term enrollees (Table 4-3).

**Table 4-2. Medicare Managed-Care Enrollees That Have Been Enrolled for Three Years or Less (percentage)**

Time Period	Percent of All Enrollees That Have Been Enrolled for Three Years or Less
June 1993	43%
June 1994	46
June 1995	50
June 1996	55

SOURCE: Physician Payment Review Commission analysis of Medicare Enrollee Data Base file, 0.5 percent sample.

**Table 4-3. Length of HMO Enrollment for Medicare Enrollees in Five Large Risk Contracts, June 1994**

Length of Enrollment In Years	Percent of All Enrollees					Total for Top 5
	Plan A	Plan B	Plan C	Plan D	Plan E	
Under 1	11%	22%	14%	7%	18%	15%
1-2	12	23	11	6	17	14
2-3	8	13	11	5	11	10
3-4	6	8	12	5	10	8
4-5	5	6	10	6	7	7
6 or More	59	28	41	71	38	47

SOURCE: Physician Payment Review Commission analysis of Medicare Enrollee Data Base file, 5 percent sample.

NOTE: Individuals who were enrolled in the health maintenance organization (HMO) in their first month of Medicare eligibility (so-called age-ins) were placed in the "6 or more" category.

Because this approach would be used as an interim risk adjuster, the size of the payment reductions could be set to achieve policy goals rather than being driven entirely by research. Evidence on use of services prior to enrollment would suggest a very deep cut in payments for new enrollees (PPRC 1996). Evidence on regression toward the mean implies a relatively slow return toward full payment (GAO 1997). Together, however, a deep initial cut and slow return toward the mean would result in a very large overall reduction in payment. Instead, policymakers could choose to make less severe initial

cuts (and reduce the number of years to which the cuts apply) to achieve a more modest overall target for payment reductions.<sup>26</sup>

One potential improvement over a uniform payment reduction for all new enrollees would be to look separately at each plan. Rates could be based on the prior costs of each plan's new enrollees. Plans attracting beneficiaries with very low costs would be assumed to enjoy more favorable selection than those attracting beneficiaries with average costs. An alternative would be to look at new enrollees' predicted costs based on diagnoses, and to pay lower rates to plans whose new enrollees have lower predicted costs. These methods based on fee-for-service data could not be applied uniformly, however, since Medicare has no cost data on beneficiaries who age in to Medicare managed-care enrollment.

### **Risk-Adjusting County Base Rates**

A second area where existing data could be used to improve payment is the risk adjustment of the county rates that are the basis of Medicare payments to managed-care plans. The county rates are often overlooked in discussions of risk adjustment, perhaps because this is a technically difficult topic. This section of the chapter explains three independent points that favor moving ahead with risk adjustment of the county rates.

First, risk adjustment of the county base rates is part of an overall phase-in of risk adjustment of Medicare managed-care rates. To calculate the rates correctly, HCFA must apply risk adjustment both to the county base rates and to each individual plan's rate. HCFA does that now with its demographic adjustments, and HCFA will have to do that in the future with any improved risk adjustment method. Because the county rates are based on Medicare fee-for-service data, HCFA can calculate diagnosis-based risk adjustment factors for the county rates now.

Second, risk adjustment of the county rates will correct, in part, the potential inflation of those rates in areas of high managed-care penetration. Each county's rate is based on the average cost of Medicare fee-for-service beneficiaries. That rate may be inflated if healthier beneficiaries enroll in managed-care plans, leaving less-healthy beneficiaries in fee-for-service Medicare.

Third, applying diagnosis-based risk adjustment to the county rates would significantly reduce geographic variation in Medicare payment rates. This phenomenon is simply a fact that is observed when the risk-adjustment calculation is performed. Diagnosis-based risk adjustment of the county base rates captures the observed variations in the incidence of disease across counties. Incidence of disease reflects many complex factors such as genetic makeup of the population, local variations in diet, or other environmental factors.

---

<sup>26</sup> For example, based on mid-1996 data, an average payment reduction of roughly 5 percent could be achieved by reducing payments by 10 percent, 7.5 percent, 5 percent, and 2.5 percent for the first through fourth years of enrollment, respectively.



**HCFA's Current Payment Formula.** Under HCFA's current managed-care payment formula, a plan's payment rate in a county is determined by three factors: average fee-for-service spending in each county, the demographics of the plan's enrollees, and the demographics of the fee-for-service beneficiaries in the county. Discussions of risk adjustment often neglect the impact of the demographics of the fee-for-service enrollees. In practice, as described below, the plan and county demographic factors play an equal role in determining plan payments.

Mathematically, each plan's payment is the product of average county fee-for-service spending and the plan's demographic factor, divided by the demographic factor for the fee-for-service enrollees in the county. The payment formula can be interpreted in two equivalent ways. One way to describe the formula is that HCFA first takes the county spending numbers and removes a factor to account for the demographics of the fee-for-service beneficiaries in the county. In effect, HCFA calculates what spending would have been if the county's demographics had matched the national average. HCFA then adds back in a separate factor to account for the demographics of the plan's enrollees.<sup>27</sup> An equivalent way to describe the formula is that each plan's rate is based on the average fee-for-service spending in a county, adjusted for any differences between the demographics of the plan's enrollees and the demographics of the fee-for-service beneficiaries in the county. For example, if a plan attracted beneficiaries that were younger than the average in the county, HCFA would reduce the plan's payment rate below the average fee-for-service spending in the county.<sup>28</sup>

In either case, the adjustment for the demographics of fee-for-service beneficiaries in the county is done to avoid double-counting of costs. If a plan attracts the average fee-for-service beneficiary in a county, it should receive a payment that matches average fee-for-service spending in the county.<sup>29</sup> To achieve that, the demographics of both the managed-care and fee-for-service beneficiaries must enter into the payment formula.

Full implementation of diagnosis-based risk adjustment would require calculating adjustments for both the managed-care enrollees in each plan and the fee-for-service beneficiaries in each county. The logic for doing this is identical to the adjustment for demographics. If spending in a county is high because the fee-for-service beneficiaries have costly illnesses, HCFA does not want to take that high level of spending and inflate it further if a plan merely enrolls the average beneficiary in that county. The higher payment for a costly diagnosis must be counted only once, so HCFA must remove the effects of diagnoses from the county base rates.

In that context, risk adjustment of the county base rates alone can be viewed as part of a phase-in of diagnosis-based risk adjustment. At this time, diagnosis data are not available on plans' enrollees, but

---

<sup>27</sup> Here, the payment formula can be expressed as:  $\text{plan payment} = (\text{county spending} / \text{county demographics}) * (\text{plan demographics})$ .

<sup>28</sup> Here, the payment formula can be expressed as:  $\text{plan payment} = (\text{county spending}) * (\text{plan demographics} / \text{county demographics})$ .

<sup>29</sup> For simplicity, this discussion ignores the 5 percent discount built into HCFA's managed-care payment rates.

are available on Medicare claims for the fee-for-service population in each county. The fee-for-service risk-adjustment factor could be used to remove the effects of variation in incidence of illness from the existing county base rates. Risk adjusting the county base rates in this fashion would be a step toward full implementation of diagnosis-based risk adjustment.

**Risk Selection and Inflation of County Rates.** Analysts have long noted that risk selection may inflate county rates in areas with high managed-care enrollment. If managed-care plans attract healthy people, then beneficiaries who stay in fee-for-service Medicare are less healthy and hence costlier than average. This risk selection would increase fee-for-service spending and raise the county rates, particularly in areas with high managed-care penetration and significant risk selection (Rossiter and Adamache 1990).

The General Accounting Office (GAO) has recently suggested recalculating the county-level base rates to remove this bias (GAO 1997). GAO would use information on new enrollees' low costs prior to enrollment, along with estimates of regression toward the mean, to recalculate the county base rates and remove the effects of risk selection from the county rates (GAO 1997).

Diagnosis-based risk adjustment of the county base rates is an alternative approach to deflating the county rates. If managed-care plans attract healthier beneficiaries, the remaining fee-for-service population will have a higher incidence of serious illnesses. Diagnosis-based risk adjustment of the county rates would remove the inflationary effects of risk selection.

**Empirical Effect of Risk Adjusting the County Base Rates.** The actual impact of risk adjusting the county base rates cannot be predicted a priori. Diagnosis-based risk adjustment will reflect the many different factors that drive county level variation in the incidence of diseases. The net effect of removing that variation can only be determined by actually calculating the risk adjustments using Medicare claims data, and the usefulness of the risk adjustment rests on whether it appears to move payments in a desirable direction. As discussed in more detail in Chapter 3, risk adjustment would reduce the wide geographic variation in Medicare payment rates, and thereby help to solve a long-standing problem in Medicare managed-care payment.

Applying diagnosis-based risk adjustment to the county base rates will remove the effects of all observed variation in the incidence of illness. One source of that variation—the inflationary effect of risk selection—was discussed above. But many other factors might also drive the observed county-level variation in the incidence of illness. For example, the genetic makeup of the beneficiary population, local environmental hazards, presence of a retirement destination community, or regional variations in diet may all affect the incidence of disease in a county. In addition, variations in diagnosis reporting by fee-for-service physicians may affect the apparent level of illness observed from Medicare claims data.

The net impact of risk adjusting the base rates can be approximated by applying the HCC methodology to existing Medicare fee-for-service claims. Based on an initial estimate using a 5 percent sample of data, this adjustment would largely reduce the county base rates in high-cost areas and raise

them in low-cost areas (Table 4-4). For example, Miami, Los Angeles, and several other areas noted for their very high rates would experience significant payment reductions (Table 4-4). Conversely, Minneapolis and Seattle, areas with high managed-care penetration but relatively low payment rates, would see a significant increase in rates (Table 4-4). Payment rates would increase modestly in most rural areas.

**Table 4-4. Effect of Risk Adjustment on County Base Payment Rates, Top 50 Metropolitan Statistical Areas or State Rural Areas**

Metropolitan Area or Rural Portion of State	Average 1995 AAPCC (A)	HCC Risk Adjustment Factor (B)	Diagnosis Adjusted Base Rate (A/B)	Sample Size
Miami, FL	\$616	1.34	\$460	9,700
Los Angeles-Long Beach, CA	559	1.13	495	29,700
Detroit, MI	544	1.23	442	29,500
New York-Newark, NY-NJ-PA	530	1.05	505	110,800
Philadelphia, PA-NJ	527	1.15	459	33,300
Baltimore, MD	498	1.08	460	15,700
Pittsburgh, PA	494	1.07	460	22,100
Houston, TX	489	1.00	490	13,000
San Diego, CA	459	1.04	440	8,600
Chicago, IL	458	1.02	448	42,200
Cleveland-Lorain-Elyria, OH	454	1.07	424	16,300
Boston, MA-NH-ME-CT	446	1.05	426	40,200
Washington, DC-MD-VA-WV	443	1.00	441	19,700
Phoenix-Mesa, AZ	440	0.98	450	11,400
Atlanta, GA	435	1.01	431	15,100
Dallas, TX	426	0.98	433	12,600
Kansas City, MO-KS	421	1.01	417	9,500
Tampa-St. Petersburg-Clearwater, FL	418	1.12	372	18,700
St. Louis, MO-IL	407	1.07	380	17,500
Hartford, CT	406	0.99	409	9,100
Cincinnati, OH-KY-IN	403	1.01	400	10,600
Indianapolis, IN	397	1.02	388	9,000
Milwaukee-Waukesha, WI	381	0.95	402	10,300
FL Rural	376	1.08	348	9,700
PA Rural	373	1.07	350	16,100
Seattle-Bellevue-Everett, WA	373	0.91	408	9,700
TN Rural	365	1.01	360	14,800
Buffalo-Niagara Falls, NY	361	0.98	370	10,000
AL Rural	356	1.02	350	11,200
WV Rural	355	1.04	341	8,500
Minneapolis-St. Paul, MN-WI	351	0.89	393	9,300
GA Rural	348	1.04	335	16,400
MI Rural	346	1.04	334	13,800
KY Rural	344	1.01	341	15,600
MS Rural	336	1.00	335	14,400
TX Rural	335	0.97	346	24,400
VA Rural	331	1.00	331	12,300



**Table 4-4.** (continued)

Metropolitan Area or Rural Portion of State	Average 1995 AAPCC (A)	HCC Risk Adjustment Factor (B)	Diagnosis Adjusted Base Rate (A/B)	Sample Size
NY Rural	331	0.99	334	11,200
OH Rural	329	0.99	334	15,300
NC Rural	320	0.97	330	20,500
IN Rural	319	0.98	326	12,000
KS Rural	315	0.96	329	10,000
AR Rural	313	0.96	327	12,900
IL Rural	304	0.97	312	16,500
OK Rural	301	0.95	318	11,400
MO Rural	300	0.98	307	14,900
SC Rural	290	1.00	289	8,300
IA Rural	280	0.88	319	14,500
WI Rural	269	0.90	300	13,300
MN Rural	263	0.85	310	12,200

**SOURCE:** Physician Payment Review Commission analysis of Medicare 1994 and 1995 Standard Analytic Files and Medicare Enrollee Database File, 5 percent sample.

**NOTES:** Average AAPCC rate is the average of all counties in the market area, weighted by the Medicare fee-for-service enrollment in each county.

The HCC factor is a risk adjustment factor based on the Hierarchical Coexisting Conditions model. HCCs were calculated based on 1994 diagnoses.

The Diagnosis Adjusted Base Rate standardizes each county to the national average population. It shows what the payment would be, in each market area, for the national average beneficiary.

## PHASING IN RISK ADJUSTMENT

In the Commission's view, there appears to be little rationale for waiting for risk-adjustment methods to improve further. Currently available methods would capture a significant portion of the risk selection that occurs, and using any of the best available methods would substantially improve Medicare's approach to paying managed-care plans.

The introduction of risk-adjusted payment rates entails more uncertainty than any previous major changes in Medicare payment rates. When diagnosis-related groups and the Medicare Fee Schedule were proposed, data were available to simulate the effect on individual providers. Policies were judged, in part, on the redistribution of money across sectors of the industry, and long phase-ins were incorporated to prevent sudden and sharp payment changes. By contrast, until data are available from managed-care plans (either diagnosis data or surveys), there is almost no information to demonstrate how risk adjustment affects rates for individual plans.

Because there is no information on the effect of change, and since new data systems must be put into place, new risk-adjustment methods should be phased in. The simplest approach would be to set some limit on the maximum payment change applicable in one year, similar to the limits on conversion factor reductions under Medicare physician payment reform. This strategy would provide plans with some security that they would not be subject to violent payment swings. At the extreme, all payment changes could be phased in by reducing or eliminating updates. This approach would ensure that plans would not see absolute declines in payment. Rates would be frozen until they reached the appropriate risk-adjusted levels.

An alternative would be to base the speed of the phase-in on some market indicators of excess payment. Medicare might take into account plans' adjusted community rate (ACR) filings (an accounting measure of plans' costs) or the average level of additional benefits that plans offer in each market. Market areas where Medicare payments greatly exceed costs and where beneficiaries receive significant additional benefits might be better able to accommodate payment changes. In areas where Medicare payments are closer to costs and plans offer few additional benefits, any required reductions might be made more slowly to avoid disruption of existing managed-care arrangements.

In either case, the Medicare program should immediately begin to phase in risk-adjusted rates using administrative data. A combination of somewhat lower rates for new enrollees, and modest adjustment of the county-level base rates, could move Medicare payments in the proper direction now while the data resources needed for permanent and more accurate changes are being developed.

In the long term, the data and infrastructure required to support risk adjustment based on the best available data should be developed and implemented. Diagnosis information from encounter data would provide the most stable payment rates, but would impose significant costs on plans and on the Medicare program. A summary of each beneficiary's diagnoses might be an adequate substitute for encounter data. Survey data could be obtained almost immediately, and could be used to move payment rates part way toward fully risk-adjusted payment.

Implementation of risk-adjusted rates will not be easy, but the liabilities associated with risk adjustment need to be weighed against the drawbacks of failing to make those adjustments. Increased Medicare spending due to risk selection also means larger-than-necessary payments to plans. Reducing payment rates will not be popular, and reductions will involve more money and more beneficiaries the longer this problem is left unresolved. The Medicare program should begin taking prudent steps now to develop the infrastructure for improved risk adjustment, establish the orderly implementation of data reporting, further develop risk-adjustment methods, and phase in adjusted payment rates.

## REFERENCES

- Ash, Steven, Liz Sloss, Richard Kravitz, et al., *Access to Care for the Elderly Project (ACE-PRO)*, final report to the Physician Payment Review Commission (Santa Monica, CA: RAND, April 1995).
- Berki, S.E., and Marie L.F. Ashcraft, "HMO Enrollment: Who Joins and Why: A Review of the Literature," *Millbank Memorial Fund Quarterly* 58(4):588-632, 1980.
- Ellis, Randall P., Gregory C. Pope, Lisa I. Iezzoni, et al., "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," *Health Care Financing Review* 17(3):101-128, Spring 1996.
- General Accounting Office, *PRO Review Does Not Assure Quality of Care Provided by Risk HMOs*, GAO/HRD-91-48 (Washington, DC: March 1991).
- General Accounting Office, *Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving the Accuracy of County Payment Rates*, GAO/T-HEHS-97-78 (Washington, DC: February 25, 1997).
- Newhouse, Joseph P., "Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection," *Journal of Economic Literature* 34(3):1236-1263, September 1996.
- Newhouse, Joseph P., "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs* 13(1):132-146, Spring (I) 1994.
- Park Nicollet Medical Foundation, *A Comparison of Alternative Approaches to Risk Measurement*, Selected External Research Series, No. 1 (Washington, DC: Physician Payment Review Commission, December 1994).
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington DC: 1996).
- Riley, Gerald, Cynthia Tudor, Yen-pin Chiang, et al., "Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994," *Health Care Financing Review* 17(4):65-76, Summer 1996.
- Riley, Gerald, Evelyne Rabey, and Judith Kasper, "Biased Selection and Regression Toward the Mean in Three Medicare HMO Demonstrations: An Analysis of Enrollees and Disenrollees," *Medical Care* 27(4):337-351, April 1989.
- Rossiter, Louis F., and Killard W. Adamache, "A Blended Sector Rate Adjustment for the Medicare AAPCC," *Journal of Risk and Insurance* 58(2), June 1990.



- Welch, W. Pete, "Regression Toward the Mean in Medical Care Costs," *Medical Care* 23(11):1234-1241, 1985.
- Welch, W. Pete and H. Gilbert Welch, "Fee-for-Data: A Strategy to Open the HMO Black Box," *Health Affairs* 14(4):104-116, Winter 1995.
- Wrightson, C. William, James S. Genuardi, David R. McKusick, et al., *Actuarial Methods for Improving HCFA Payments to Risk HMOs*, report to the Health Care Financing Administration under Cooperative Agreement No. 17-C-90033/3 (Annandale, VA: Actuarial Research Corporation, April 12, 1996).

# Promoting Access to Care for Vulnerable Populations in Medicare Managed Care

Medicare managed care offers the potential for improving access and enhancing care for vulnerable beneficiaries through better coordination of care, and more flexibility in the management and delivery of health services. Inadequate protection against high costs and catastrophic losses, however, may keep managed-care plans from providing outreach to these groups and developing new approaches to health care delivery best suited to their needs. Health plans with special programs or providers for serving vulnerable groups may attract sicker, costlier patients who put the plan at risk for substantial losses.

Improving risk adjustment in Medicare capitation payment policy is critical for promoting access for vulnerable groups. Primarily, adequate risk adjustment is necessary to avoid losses to the Medicare program, and to focus competition among plans on value instead of selection. In addition, adequate risk adjustment is essential for preventing barriers to serving high-cost beneficiaries by ensuring that more costly groups of enrollees do not lead to larger losses relative to less costly groups. Improving incentives for serving high-cost beneficiaries will require further refinement of risk adjustment methods, such as incorporating clinical diagnoses, functional status, and self-reported health status. Issues of implementing improved risk adjusters in Medicare managed care are discussed in Chapter 4.

Risk sharing, which protects plans from the catastrophic losses of exceptionally expensive episodes of care, is another payment

*This chapter includes:*

- *Complexity of identifying and defining vulnerable groups*
- *Assessment of methods for improving risk adjustment for vulnerable groups*
- *Challenges of promoting innovative and effective service delivery for vulnerable groups*
- *Recommendations on risk adjustment and other mechanisms for promoting innovative and effective service delivery for vulnerable groups*

mechanism that would promote access for vulnerable groups. An outlier payment policy is one risk-sharing approach that would give plans an extra retrospective payment for exceptionally costly patients. Compared with better risk adjustment, however, an outlier policy would not improve payment as effectively. Other risk-sharing mechanisms, such as “risk corridors” for plans’ profits and losses, may prove useful as part of demonstrations to encourage the development of specialized programs for serving vulnerable groups.

Promoting access for vulnerable groups in Medicare managed care will also require developing and evaluating innovative health care delivery strategies and assessing whether they improve outcomes. Dissemination of information to plans on the success and failure of innovative strategies will help successful strategies proliferate yet deter unsuccessful ones.

## *Recommendations*

*In developing improved risk adjusters, the Congress should direct the Health Care Financing Administration (HCFA) to recognize the importance of ensuring access for vulnerable groups in Medicare managed-care plans. As part of these efforts, HCFA should develop, evaluate, and implement risk adjusters that incorporate clinical diagnoses, functional status, and self-reported health status.*

*The Congress should direct the Health Care Financing Administration (HCFA) to pursue demonstrations of a broad range of innovative and effective health care delivery approaches for vulnerable groups in managed care. These demonstrations should identify approaches to provide care both within Medicare managed-care plans, and through specialized arrangements when appropriate. HCFA should develop flexible funding mechanisms for these demonstrations, which might include higher capitation payments, risk sharing, and start-up funds.*

*The Congress should direct an agency, such as the Agency for Health Care Policy and Research, to develop a research framework for promoting access for vulnerable groups in Medicare managed care. In addition, the agency should coordinate public and private efforts to evaluate and disseminate innovative health care delivery strategies.*

As the debate over restructuring Medicare continues, it is important to understand the access problems vulnerable populations could potentially face. Policies designed to meet the health needs of typical beneficiaries may not meet the needs of those who are more vulnerable. Identifying potential barriers to access for vulnerable groups is difficult, however, because policies for restructuring Medicare are not yet in place, and overall enrollment in Medicare managed care, although growing, is relatively low at about 13 percent.



Lessons for Medicare managed care can be drawn from the Medicaid program. States have increasingly looked to managed care to control costs and improve access and quality for their Medicaid population. Some have adopted a wide range of managed-care models and financing arrangements, and, in some instances, have made enrollment in managed-care plans mandatory. Because the Medicaid program covers some of the most vulnerable groups, it provides useful insights and illustrates the complexities of various approaches for promoting access for this population.

This chapter draws from experiences in the Medicaid program to highlight the key issues related to promoting access for vulnerable groups in Medicare managed care. First, it discusses the difficulty of identifying and defining those groups that require special consideration. It then considers the need for risk adjusters and risk-sharing mechanisms to ensure adequate access for those at risk of incurring high costs. Analyses of the Medicare Current Beneficiary Survey (MCBS) are used to describe vulnerable groups and the potential implications of various risk adjusters and outlier payment policies. Finally, the chapter discusses the challenges of promoting innovative service delivery for vulnerable groups in Medicare.

## **IDENTIFYING AND DEFINING VULNERABLE GROUPS**

Two groups of beneficiaries may be the most vulnerable to problems of access under capitated arrangements. The first group comprises those who require specialized care or more resource-intensive care on an ongoing basis. These individuals may have above average annual costs associated with their care, or may be more likely to have exceptionally expensive acute episodes.

The second vulnerable group includes those who have difficulty navigating systems of care, whether because of medical, psychological, economic, sociological, or other factors. Managed-care arrangements may be problematic for them because of gatekeeper arrangements, a limited choice of providers, and insufficient education concerning the plan's or the medical group's internal guidelines.

Improving payment policy is crucial for both groups of beneficiaries. Without adequate payment, managed-care plans may not develop specialized services that would attract more enrollees from costlier subgroups. Nor would they be likely to develop an infrastructure of outreach and follow-up to help beneficiaries who have difficulty navigating the system.

Developing strategies for promoting innovative health care delivery is also important to ensure access for both groups of beneficiaries. Costlier beneficiaries like those with chronic illnesses may benefit from health delivery approaches specifically designed to meet their needs. Approaches to care that emphasize same-day appointments and urgent care target acute illnesses, but may fail to provide the ongoing care management required by those with chronic illnesses (Wagner 1996). In addition, beneficiaries who struggle to navigate systems of care would benefit from new approaches that facilitate access.

Improved payment policies and strategies for promoting health care delivery will require accurate and objective definitions of at-risk populations. Otherwise these policies will be hard to implement, open to gaming, and applied to some persons inappropriately. Some definitions, such as “having one or more chronic illnesses,” are less precise than they seem. For example, a Medicaid program designed to serve chronically ill children could apply to less than 5 percent and up to 30 percent of all children, depending on the conditions chosen to define the chronically ill (Newacheck and Taylor 1992). In Medicare, a program that targets the chronically ill could apply to well over 60 percent of all beneficiaries.

Using specific clinical diagnoses to define vulnerable subgroups can also be problematic. It can lead to increased diagnosis of specific conditions, especially when these conditions receive higher payments. For example, under the prospective payment system (PPS) for inpatient hospital care, most of the increase in the case mix index after the first year of implementation could be attributed to upcoding rather than greater resource needs (Carter and Ginsburg 1985). Moreover, inequities in payment across geographic areas can be heightened by policies that rely heavily on diagnostic criteria. Areas where services are more available and more heavily used may receive higher payments because these areas will have greater numbers of persons with particular diagnoses. Finally, strategies that rely on clinical diagnoses may emphasize more prevalent diagnoses like diabetes, overlooking those that are less widespread like dementia.

### **The Medicaid Experience**

Medicaid coverage is offered to a broad range of vulnerable groups that meet an assortment of eligibility criteria, many designated at the federal level. Examples include people receiving Aid to Families with Dependent Children (AFDC), poor pregnant women and children, and Supplemental Security Income (SSI) beneficiaries (the aged, blind, and disabled with low incomes). A majority of states also provide Medicaid coverage to the medically needy, for example, those who qualify due to a disability, but do not meet the applicable income standard.

In addition to eligibility criteria, categorization of the Medicaid population can be based on the medical need. These categories include children with special needs, the institutionalized aged, and the seriously mentally ill. Medical categories better describe the potential health care needs of these subgroups.

States have implemented managed-care arrangements beginning with populations, such as people receiving AFDC, whose health care needs are less intense or specialized compared with other Medicaid populations. More recently, however, some states have expanded managed-care enrollment to populations with special health care needs. For example, of the 19 states that have mandatory managed-care enrollment for AFDC eligibles, 6 make it mandatory for children with special needs and 5 make it mandatory for the institutionalized aged (Horvath and Kaye 1995).

Although states have found the eligibility criteria useful for the initial steps of implementing managed-care arrangements for many of their Medicaid recipients, these criteria are not always specific enough for some subgroups with specialized health care needs. For example, children with special needs may belong to families that qualify for Medicaid because of their AFDC eligibility. Consequently, some states have adopted the strategy of classifying children with special needs based on diagnostic criteria, and provide programs designed specifically for them. These approaches make a trade-off between whether the children receive care in the same plan as their families or in a separate plan that specializes in their care.

Examples of three programs illustrate the variety of approaches used in Medicaid. The District of Columbia has a specialized program that applies to all children and youths under 22 receiving Supplemental Security Income. The program excludes children who are dually eligible for Medicare and Medicaid, and children with special needs in families eligible for AFDC.

Arizona contracts separately with four regional providers for the care of children who need rehabilitative services. Eligibility for these specialized or so-called “carve-out” providers is based on a combination of diagnosis and financial need. Children in eight diagnostic categories (cerebral palsy, cleft palate, cystic fibrosis, myelomeningocele, neurofibromatosis, metabolic disorders, scoliosis, and sickle cell anemia) qualify regardless of the family’s financial circumstances. Children with other chronic illnesses or physical disabilities from low-income families are eligible at no cost, while those whose families do not meet the income standards are eligible with a copayment tied to family income (Echeverria 1996).

Boston’s Community Medical Alliance, which serves two special Medicaid populations (the severely disabled and AIDS patients), aims to prolong independent living through home- and community-based care. It assigns enrollees a health care team that combines intensive case management with direct provider care, thereby ensuring round-the-clock availability of care. Eligibility for the program serving the severely disabled requires that patients have permanent triplegia or quadriplegia; need personal care attendant services; and have a diagnosis such as spinal cord injury, cerebral palsy, or muscular dystrophy. To be eligible for the AIDS program, persons must meet the Centers for Disease Control definition of AIDS and have at least one opportunistic infection, malignancy, or other sign of advanced HIV infection (Master 1996).

### **Identifying and Defining Vulnerable Groups for Medicare**

Identifying and defining vulnerable Medicare enrollees is important for two reasons. First, improving payment policies and promoting innovative health care delivery approaches will depend on defining to whom these policies and approaches will apply. Second, plans must be able to identify vulnerable enrollees who might benefit from any new delivery approaches.

The Medicare program has only three distinct classes of eligibility: the aged, the disabled, and persons with end-stage renal disease (ESRD). Separate provisions, already in place for ESRD patients, will most likely continue to be necessary owing to the high cost of their care. Average annual expenditures per ESRD beneficiary were \$35,104 in 1992, compared with \$3,790 for all Medicare beneficiaries



(Committee on Ways and Means 1994). Although, current risk adjustors distinguish between the aged and the disabled, they have proven inadequate for guaranteeing appropriate payment.

Concerns about improving payment and ensuring access and quality in managed-care plans often focus on people with chronic conditions, which are associated with higher costs and the need for specialized providers (Jones 1996). Using chronic conditions to identify vulnerable persons is problematic, however. First, about 62 percent of Medicare beneficiaries can be classified as chronically ill, even after the more common and less severe chronic conditions like high blood pressure and arthritis are excluded (Table 5-1).<sup>1</sup> Second, except for ESRD, no other chronic conditions stand out as exceptionally more costly, on average, than any other. For example, average annual payments for most chronic conditions range from about \$6,000 to \$8,000, while annual median payments range from about \$1,200 to \$1,900. Moreover, no chronic condition is more likely to place someone in the top 5 percent to 10 percent of the costliest beneficiaries. As a result, none of the chronic conditions except ESRD is a candidate for carve-outs or exceptions.

**Table 5-1. Distribution of Annual Charges for Potentially Vulnerable Medicare Beneficiaries**

Vulnerable Population Category	Percent of Beneficiaries	Average Annual Payments	Annual Median Payments	Percent of Beneficiaries in the Top 10% of Cost	Percent of Beneficiaries in the Top 5% of Cost
Any Self-Reported Condition	71%	\$5,491	\$1,138	0.6%	0.2%
Any Self-Reported Chronic Condition	62	5,638	1,224	0.6	0.2
Major heart condition	23	7,234	1,855	1.0	0.4
Rheumatoid arthritis	14	5,743	1,373	0.6	0.1
Any psychiatric condition	13	6,259	1,320	0.7	0.2
Any physical condition	18	6,888	1,590	0.9	0.3
Stroke	12	8,203	1,850	1.3	0.5
Diabetes	17	7,040	1,507	1.3	0.5
Emphysema	14	6,739	1,379	1.0	0.4
Medicare Disabled, Not ESRD	11	4,041	613	0.6	0.1
Functional Disability, Needs Help	19	9,975	2,886	1.6	0.6
Institutionalized	6	13,849	2,737	0.8	0.5
Age 85 and Over	11	6,245	1,524	0.3	0.1
Dually Eligible	15	12,235	1,376	0.6	0.2
Poor Health	4	11,779	3,508	2.5	1.1
Overall	100	4,379	803	0.4	0.2

SOURCE: Physician Payment Review Commission analysis of the 1995 Medicare Current Beneficiary Survey.

NOTE: In 1995, beneficiaries with annual payments exceeding \$94,000 accounted for 5 percent of total Medicare outlays, while those exceeding \$63,000 accounted for 10 percent.

<sup>1</sup> The 1995 MCBS was used to explore the usefulness of chronic conditions for classifying Medicare beneficiaries. Functional disabilities and other characteristics associated with higher-than-average costs of care were also considered. For these analyses, managed-care enrollees were omitted because claims information was unavailable for them. In addition, ESRD patients and any beneficiary who did not survive the year were excluded. Therefore, these analyses may omit some of the highest-cost cases, but should be fairly representative of likely annual spending for particular groups on an ongoing basis.

Beneficiaries in categories other than chronic illness also demonstrate above-average costs (Table 5-1). These include people who need help with daily living, the institutionalized, the oldest old, dual eligibles, and those in poor health. Some of these categories, like those who report poor health or those with functional impairment, may provide additional information about the severity of a beneficiary's chronic illness. Taken by themselves, however, these categories represent fairly heterogeneous groups that would be insufficient for improving payment or developing new health delivery strategies. This observation suggests that policies and programs may have to target individuals whose costs are high or who have difficulties navigating systems of care rather than relying entirely on classifications that serve as proxies.

Identifying vulnerable beneficiaries within a health plan may require general strategies that initially encompass all Medicare enrollees. To better understand the approaches health care organizations take to identify these groups and ensure their access to care, the Physician Payment Review Commission convened a panel of experts with experience in providing managed care to vulnerable groups. The panel discussed the potential barriers vulnerable groups may face in managed-care plans, and described successful strategies for ensuring access and improving care. It observed that managed-care plans should adopt general strategies for identifying vulnerable individuals rather than targeting specific subgroups. Attempts to target specific subgroups, it noted, would inevitably fail to single out other vulnerable persons who do not meet the specific criteria.

Plans' strategies to guarantee access for vulnerable enrollees may require efforts besides those needed for the typical plan member. The expert panel cited outreach, risk screening, assessment, and follow-up as key among a range of strategies for overcoming and preventing barriers to care. Direct contact initiated by the plan or the provider may be a more effective approach than relying on these enrollees to request care themselves. Additionally, vulnerable groups may require more intervention than simply receiving informational materials about specific programs with the expectation that enrollees will seek care based on this information.

Outreach and screening may be a health plan's first contact with a new and potentially vulnerable enrollee, enabling it to educate the person about the plan and to determine whether the enrollee has special needs. Outreach may begin with materials that explain how the health plan operates and that help the new enrollee pick a primary care provider. Some plans follow up with a welcoming telephone call, introducing the enrollee to the system and explaining how it works.

Screening is another tool that allows a health plan to identify those new enrollees at high risk for functional decline or those who may benefit from management of chronic conditions such as diabetes and asthma. Screening can ascertain whether individuals have functional impairment, common clinical syndromes, or multiple conditions. Alternatively, the plan can screen for characteristics that would make it harder for someone to use the system, such as lack of transportation, lack of a caregiver or social support, or caregiver responsibilities.

Of the seven largest health maintenance organizations (HMOs) that serve the elderly, five screen new enrollees. Some use mailed questionnaires, while others screen by telephone. Since the response rate to mailed questionnaires is only about 60 percent, other strategies are necessary to ensure that health plans reach all vulnerable members (Pacala 1995).

About 96 percent of new Medicare managed-care enrollees receive a booklet explaining how their plan works, and 38 percent are encouraged by the plan to have a physical exam or health assessment after enrolling (Nelson et al. 1996). About 90 percent of all managed-care enrollees visit a plan physician within the first year.<sup>2</sup> Therefore, many of those not identified by screening can be assessed at that time and referred to case management or specialized programs. More aggressive approaches, such as home visits, may be necessary to contact those few enrollees who have neither visited a plan physician nor been reached by telephone during the first year.

Some managed-care plans also incorporate a review of medications into a new enrollee's first contact. In such situations, new enrollees bring all the medications they are using for review by the health plan's pharmacist. The pharmacist can then identify the potential for adverse effects from drug interactions (Kramer 1992). Reviewing medications may also provide insight into new enrollees' health problems and how these have been managed.

## **IMPROVING CAPITATION PAYMENT POLICY**

Adequate capitation payments through effective risk adjustment are essential for ensuring access to care for vulnerable groups. Without adequate risk adjustment, a poorly performing health plan may prosper if it attracts enough low-cost beneficiaries, while an efficient plan may struggle if burdened with many high-cost patients. Concern over attracting too many costly patients may also keep some plans from developing innovative programs designed to benefit specific vulnerable groups. The Commission's expert panel considered adequate reimbursement critical for managed-care plans to be able to ensure access and appropriate care delivery for vulnerable populations.

Risk adjusters prospectively modify capitation payments for specific subgroups so that the payments more accurately match the cost of their care. In Medicare, the payments reflect what Medicare would have spent on HMO enrollees had they remained in the traditional fee-for-service program. Because of unpredictable aspects of health care needs, a risk adjuster cannot be expected to achieve accurate payments for a given individual, but should provide appropriate payment, on average, across subgroups of enrollees.

Currently, capitation payments to Medicare risk-contracting plans are based on local average fee-for-service costs per capita. Medicare uses additional information on beneficiaries' demographics to adjust

---

<sup>2</sup> Based on the Commission's analysis of data from its 1996 survey of Medicare risk plan enrollees and disenrollees. (Nelson et al. 1996).



these capitation rates for costs associated with these characteristics. For example, because health care costs generally increase with age, Medicare pays higher capitation rates to plans that enroll older beneficiaries. This risk-adjustment method is often criticized, however, because age, gender, and the other factors now in use do not account sufficiently for variation in costs.<sup>3</sup>

Risk sharing provides another tool for reducing the risk associated with unpredictable costs and less-than-perfect risk adjustment by correcting payments retrospectively based on actual service use during health plan enrollment. Risk corridors adjust payments based on the health plan's aggregate profits and losses, while outlier payment policies provide additional payment for the exceptionally high costs of particular individuals. Neither of these policies is used in the Medicare program, except as part of demonstrations.

### **The Medicaid Experience**

As described earlier, states offer Medicaid managed-care arrangements based on different eligibility and diagnostic criteria. States also differ on which services may be covered under the various managed-care arrangements and how they are paid. As a result, states show a broad range of carve-outs for both services and populations. For example, 4 states enroll children with special needs in capitated plans but carve out selected services; 12 others offer risk plans to children with special needs, 4 of which are specialized plans.

Carving out subgroups of the Medicaid program and providing for their care in specialized programs leads to implicit risk adjustment. These programs receive a capitation payment that reflects what the subgroup would have cost under a fee-for service arrangement. For example, the monthly capitation payment for special needs children in the District of Columbia is about \$1,000, 97.5 percent of the expected fee-for-service costs (Cunningham 1995). For Boston's Community Medical Alliance, the monthly capitation payments are about \$2,000 for those with severe physical disabilities, and about \$3,800 for persons with AIDS (Master 1996).

Although capitation payments for some subgroups in Medicaid may be substantially higher than those for other groups, many of the specialized programs have risk-sharing arrangements with the Medicaid program as extra protection against large losses. For example, all of the five states with mandatory managed-care enrollment for the institutionalized aged provide additional risk-sharing protection for the managed-care plans.

The risk-sharing approaches used by Medicaid programs include various combinations of stop-loss limits on catastrophic care, partial capitation, and risk corridors. Minnesota, for example, includes a stop-loss limit on catastrophic inpatient care. Ohio uses a risk-sharing arrangement in which the plan

---

<sup>3</sup> The Commission addressed problems of risk selection and risk adjusters in its Annual Report to Congress 1996 (PPRC 1996). A discussion of issues of implementing risk adjusters is presented in Chapter 4.

takes the first 5 percent of profits and losses. The state and the plan split profits and losses ranging from 5 percent to 20 percent, while the state takes all profits and losses above 20 percent.

Risk corridors not only limit losses from catastrophic cases, but can remedy problems of setting the capitation payment too high or too low. Appropriate capitation payments may be difficult to determine for some special populations due to a lack of information about the costs of their care. A risk corridor returns excess profits to the Medicaid program if the capitation payment is too high, and provides additional payment to the plan if the payment was too low. This risk sharing approach requires the plan to provide cost-report information to the state.

### **Improving Capitation Payment Policy in Medicare Managed Care**

Improvements to the payment methodology intended to ensure access for vulnerable groups in Medicare managed care must address two issues. First, vulnerable groups are associated with higher costs on average. Commission analyses of the MCBS show that average annual payments for Medicare beneficiaries in any of the potentially vulnerable groups identified by the survey are about \$5,491 (Table 5-1). By contrast, average payments for all Medicare beneficiaries represented in the MCBS are about \$4,379 per year. Most notably, those in poor health, the institutionalized, and the dually eligible have average annual payments more than twice those for all beneficiaries. If capitation payments for vulnerable groups do not match these additional costs, these groups will represent potential losses for plans. Further, it is unlikely that a plan would be willing to invest in a special program for a particular vulnerable group with the expectation of significant annual losses. Improvements in payment methodology should therefore be designed to reduce the average losses associated with caring for those in vulnerable groups.<sup>4</sup>

Second, some vulnerable groups are more likely to incur catastrophic losses. For example, beneficiaries with major heart conditions, stroke, diabetes, and emphysema are about twice as likely to be in the top 5 percent and 10 percent of Medicare outlays. But not all of the chronic conditions associated with above-average annual payments are necessarily associated with catastrophic losses. Beneficiaries with rheumatoid arthritis and psychiatric conditions represent average risks.

Risk sharing is a mechanism for reducing the potential for catastrophic losses by providing an extra retrospective payment to offset large losses. Risk sharing can be at the individual level or at the plan level. A risk-sharing policy at the individual level makes additional payments for those whose costs exceed a predetermined threshold. One example is the outlier payment policy for inpatient hospital services under PPS. This approach reduces health plans' incentives to avoid potentially high-cost individuals or groups. Some policymakers are concerned, however, that under this approach health plans would not manage care efficiently once costs exceeded the predetermined threshold. To

---

<sup>4</sup> Risk adjustment, in general, corrects payments so they more nearly reflect the costs of care. While this chapter focuses on vulnerable groups with chronic illness and impairment, risk adjustment would also be expected to ensure adequate payment for high-cost acute care as well.

encourage health plans to continue to contain costs, the policy could be designed so that they share some of the risk of losses above the threshold (Wrightson 1996). For example, the additional payment could cover only 50 percent of costs exceeding the threshold.

Risk sharing at the plan level, however, considers only profits and losses for the plan in aggregate, rather than on a case-by-case basis. In some approaches, the plan returns profits above a certain level, but recoups large losses. This approach would encourage participation of smaller plans that serve special subgroups by reducing their risk of catastrophic losses.

**Data and Sample Design.** Commission analyses compared various strategies to improve capitation payments for vulnerable groups. Under each strategy, the profit and loss for each beneficiary was calculated. The estimates of profits and losses were developed using the MCBS, which provides information on demographic characteristics, utilization, functional status, self-reported health status, and claims data.

To calculate estimated profits and losses, each beneficiary was assigned a capitation payment amount based on county of residence, age, sex, welfare and disability status, and institutional status. Profit and loss was then calculated as the difference between the annual capitation payment and total Medicare fee-for-service payments, the proxy for actual cost in the analyses. Next, the average profits and losses for each vulnerable group were determined. For example, beneficiaries reporting poor health status had an average loss of \$7,274, compared with those reporting fair, good, very good, and excellent health who had an average profit of \$618 (Table 5-2). Overall, beneficiaries in any of the vulnerable groups studied had an average loss of \$940; those who did not belong to a vulnerable group had an average profit of \$1,920.

These analyses may overstate the size of potential losses in managed care because they used fee-for-service claims data.<sup>5</sup> Fee-for-service payments may be too high because the types of beneficiaries in fee for service differ somewhat from those enrolled in managed care (Riley et al. 1996). For example, 19 percent of beneficiaries in fee for service are functionally impaired, compared with 13 percent in Medicare managed care (Table 5-3).

Another potential bias may occur because managed care is expected to reduce costs, especially by lowering inpatient utilization. As a result, the number of services and estimates of the cost of care under fee for service may be too high. That, in turn, would also overstate the size of potential losses.

While estimates of the size of profits and losses should be interpreted cautiously, the results of the analyses presented below illustrate the potential effects of the various policy strategies; that is, the general trends demonstrate the implications of the various policies even if the size of the losses is overstated.

---

<sup>5</sup> It is necessary to use fee-for-service claims because comparable information is not available for Medicare managed-care enrollees.



**Table 5-2. Average Profit or Loss per Beneficiary Estimated from 1995 Medicare Current Beneficiary Survey Fee-for-Service Payments and 1994 Capitation Payments (dollars)**

Vulnerable Group Category	Has Condition	Doesn't Have Condition
Any Self-Reported Condition	-\$940	\$1,920
Any Self-Reported Chronic Condition	-1,135	1,577
Major heart condition	-2,644	622
Rheumatoid arthritis	-1,345	97
Any psychiatric condition	-802	15
Any physical condition	-2,319	370
Stroke	-3,254	367
Diabetes	-2,611	407
Emphysema	-2,408	318
Medicare Disabled, Not ESRD	-238	-75
Functional Disability, Needs Help	-4,459	937
Institutionalized	-694	-54
Age 85 and Over	-148	-87
Dually Eligible	75	-123
Poor Health	-7,274	618
Overall	-93	-93

SOURCE: Physician Payment Review Commission analysis of 1994 and 1995 Medicare Current Beneficiary Survey.

**Improving Risk Adjustment.** Several potential methods of risk adjustment show promise for improving payment under Medicare managed care. Some approaches, such as hierarchical coexisting conditions (HCCs), rely on clinical diagnostic information from claims data to identify the costly conditions. HCCs more accurately predict future costs of care than other methods that use diagnostic information, and will be evaluated in HCFA's Medicare Choices demonstration (Ellis et al. 1996). This methodology identifies 34 conditions, including high-cost infectious disease, cancer, diabetes, and heart problems, and predicts the cost of care for the following year based on age, sex, and 34 conditions for which care was received in the current year.

Functional status and self-reported health status are also important predictors of costs. Hornbrook and Goodman (1996) used data from nonelderly managed-care enrollees to show that combining clinical information with functional status and self-reported health status improves the prediction of health care costs. Functional status and self-reported health status enhance diagnostic information by identifying sicker enrollees with less common conditions.

To show how well clinical diagnoses and health status measures improve payments for vulnerable groups, Commission analyses compared three risk adjustment methods with the ones under current Medicare capitation payment policy. The first method used only self-reported health status measures

**Table 5-3. Beneficiaries in Vulnerable Groups by Enrollment in Managed Care or Fee for Service (percentage)**

Vulnerable Group Category	Fee for Service	Managed Care
Any Condition	70%	63%
Any Chronic Condition	62	56
Major heart condition	22	20
Coronary heart disease	15	14
Myocardial infarct	15	14
Rheumatoid arthritis	13	12
Any psychiatric condition	13	8
Mental retardation	2	1
Alzheimer's disease	4	3
Parkinson's disease	2	1
Other psychiatric disease	8	4
Any physical condition	17	15
Partial paralysis	7	5
Amputation	1	1
Osteoporosis	10	10
Stroke	12	10
Diabetes	16	15
Emphysema	15	13
Medicare Disabled, Not ESRD	11	5
Functional Disability, Needs Help	19	13
Institutionalized	6	3
Age 85 and Over	11	9
Dually Eligible	15	5
Poor Health	9	6
Overall	90	10

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

that indicated whether the beneficiary had a serious chronic condition, the number of such conditions, perceptions of health status, and whether the beneficiary had a functional disability that required help in the activities of daily living. This risk-adjustment method does not include any information about specific chronic conditions. The second risk adjuster uses HCCs, while the third combines the HCCs with functional status and self-reported health status. All three risk-adjustment methods also include the demographic information used under current policy.

Incorporating self-reported health status and functioning alone would substantially reduce losses for beneficiaries who belong to vulnerable groups. This adjustment would reduce losses from \$1,039 to \$766 for those in any vulnerable group (Table 5-4). Most notably, losses for beneficiaries who report poor health would fall from \$5,558 to about \$2,130; losses for the functionally impaired would drop from \$3,749 to about \$1,295.

**Table 5-4. Effect of Clinical Diagnoses and Health Status and Functioning Risk Adjustment on Estimated Average Profit and Loss by Vulnerable Group (dollars)**

Vulnerable Group Category	Risk Adjustment Policy			
	Current Policy	Health Status and Functioning	Clinical Diagnoses	Health Status and Clinical Diagnoses
Any Self-Reported Condition	-\$1,039	-\$766	-\$994	-\$930
Any Self-Reported Chronic Condition	-1,358	-1,028	-1,015	-986
Major heart condition	-5,288	-4,285	-3,419	-3,324
Rheumatoid arthritis	-1,033	-89	-898	-778
Any psychiatric condition	-1,258	-795	-1,161	-1,074
Any physical condition	-2,166	-984	-1,360	-1,125
Stroke	-6,958	-5,281	-4,250	-3,951
Diabetes	-1,933	-1,199	-948	-898
Emphysema	-1,859	-1,012	-754	-703
Medicare Disabled, Not ESRD	-474	-257	-443	-389
Functional Disability, Needs Help	-3,749	-1,295	-2,275	-1,268
Age 85 and Over	190	-296	-1,166	-1,050
Dually Eligible	-1,688	-1,557	-1,613	-1,556
Poor Health	-5,558	-2,130	-3,323	-2,461
Clinical Diagnoses				
High cost infectious diseases	-20,020	-18,888	-7,122	-6,934
Cancer	-4,380	-4,177	-1,077	-1,040
Blood disorders	-7,957	-7,442	147	129
Stroke	-6,945	-6,063	-2,551	-2,436
Overall	-319	-253	-759	-722

SOURCE: Physician Payment Review Commission analysis of the 1992 and 1993 Medicare Current Beneficiary Survey.

Beneficiaries with risk factors included under current policy, the Medicare disabled, the institutionalized, the dually eligible, and those 85 years and older showed smaller differences in payment than their counterparts. This result also illustrates that risk adjustment can significantly reduce the losses associated with particular subgroups.

Incorporating diagnostic information into risk adjustment would make capitation payments even more accurate. High costs can stem from acute episodes of illness, such as infections, injuries, or poisonings, or from the high costs associated with the last year of life. Acute episodes, however, are less predictable, and, thus, present less opportunity for risk selection. By using conditions diagnosed in the current year to predict costs in the upcoming year, the HCC methodology developed by Ellis and colleagues (1996) moderates the influence of acute episodes and the high costs of the last year of life. In addition, their approach excludes conditions that could potentially lead to gaming and upcoding. For



example, for all those who die, providers could code their claims with the diagnosis of respiratory arrest, and thereby receive higher payment.

Although the HCC methodology predicts prospective costs, many of the 34 conditions identified by this methodology target high-cost acute episodes from infections and poisonings, as well as conditions like metastasized cancer that usually are associated with the last year of life. For example, providers would receive about \$9,000 in extra payment for each enrollee with a diagnosis of respiratory arrest, \$6,000 for metastasized cancer, and about \$1,000 for injuries and poisonings.

To incorporate functional status, self-reported health status, and HCCs in the analyses of the MCBS, the methodology using the HCCs was modified. A model using conditions diagnosed in 1992 was used to predict 1992 costs. This model was then applied to data for 1993 to assess how well the model would risk adjust.<sup>6</sup> As a result, this analysis demonstrates the added benefit of diagnostic information rather than the specific HCC methodology developed by Ellis and his colleagues (1996).

Under current policy, the average losses for a high-cost infectious disease are about \$20,000, which would be reduced to about \$7,100 by incorporating diagnostic information (Table 5-4). Including HCCs would also lessen the average loss for those in poor health, but not as much as the risk-adjustment method based on health status.

A risk-adjustment method that combines the 34 HCC conditions with functional status and self-reported health status lowers losses for specific chronic conditions, high-cost acute conditions, and for those in poor health or with functional impairment. For example, beneficiaries with major heart conditions show average losses exceeding \$5,000 relative to those without heart conditions under current policy, but would have relative losses of about \$3,000 with a risk-adjustment approach that combined clinical diagnoses, functional status, and self-reported health status. A more sophisticated approach that combined clinical conditions and health status measures, rather than the simple approach used for these analyses, could further reduce the losses (Hornbrook and Goodman 1996).

**Outlier Payment Policy.** To ensure access for vulnerable populations, a policy should limit the size of catastrophic losses associated with caring for them. Because an outlier policy would pay for the costs of care above a given threshold, it would limit the size of potential losses for all beneficiaries whose costs exceeded the threshold, whether the beneficiary belonged to a vulnerable group or not.

HCFA is currently conducting a demonstration of an outlier policy for three Medicare HMOs in the Seattle region. This policy protects against extremely large losses, the top 2 percent of the most costly cases. The HCFA project requires encounter-level data from each of the plans and will apply Medicare fee-for-service payment methods to these services to determine which cases exceed the cost threshold.

---

<sup>6</sup> Unlike analyses presented earlier, these analyses use data for beneficiaries who died in the following year. The MCBS for 1992 and 1993 were used because claims information for nonrespondents (e.g., those who died) were available for those years.

Using the MCBS data, Commission analyses determined how much an outlier payment policy would reduce losses associated with vulnerable groups. Estimates of profits and losses were made under outlier payment policies with four different thresholds: 2 percent of outlays, 5 percent, 10 percent, and 25 percent. In order to remain budget neutral under an outlier payment policy, capitation payments would be reduced to offset the costs of the outlier risk pool. The amount reserved for the outlier risk pool would be the amount of Medicare outlays above the threshold.

Combined with an improved risk adjuster, the outlier payment policy would modestly improve the average losses associated with vulnerable enrollees. The differential would lessen as the threshold increased. For example, under a 2 percent threshold, there would be almost no reduction on average; but under a 25 percent threshold, the differential would be about \$160 less (Table 5-5). This finding supports the Commission's analyses of the effects of reinsurance shown in its *Annual Report to Congress 1996* (PPRC 1996).

**Table 5-5. Effect of Various Outlier Payment Policies and Health Status Risk Adjustments on Differences in Estimated Average Profit and Loss by Vulnerable Group (dollars)**

Vulnerable Group Category	Current Policy	Risk Adjusted, No Outlier Policy	Outlier Policy with Threshold of:			
			2 Percent	5 Percent	10 Percent	25 Percent
Any Vulnerable Group	-\$3,011	-\$704	-\$707	-\$665	-\$633	-\$540
Any Self-Reported Chronic Condition	-2,771	-393	-406	-385	-372	-310
Major heart condition	-3,374	-1,559	-1,545	-1,418	-1,355	-1,172
Rheumatoid arthritis	-1,486	688	700	602	549	490
Any psychiatric condition	-836	548	526	445	383	329
Any physical condition	-2,619	-14	-16	-50	-66	-9
Stroke	-3,697	-908	-904	-823	-772	-549
Diabetes	-3,038	-998	-979	-853	-742	-575
Emphysema	-2,756	-624	-652	-558	-496	-350
Medicare Disabled, Not ESRD	5	135	124	91	88	37
Functional Disability, Needs Help	-5,477	-1,006	-1,023	-1,074	-1,041	-896
Institutionalized	-602	-437	-439	-453	-449	-528
Age 85 and Over	-533	-475	-473	-481	-493	-497
Dually Eligible	302	307	308	298	296	236
Poor Health	-7,873	-1,921	-1,958	-1,794	-1,661	-1,268

**SOURCE:** Physician Payment Review Commission analysis of 1994 and 1995 Medicare Current Beneficiary Survey.

**NOTE:** The difference in profit and loss is calculated as the average profit or loss for those in the vulnerable group less the average profit or loss for those not in the vulnerable group. A negative difference occurs when the vulnerable group is less profitable than its counterpart, while a positive difference represents greater profitability for the vulnerable group.

To implement an outlier payment policy, a threshold is determined prospectively to establish a risk pool from which to draw outlier payments. Actual experience in the following year may, however, fall above or below these projections leading to shortages or surpluses in any given year. For example, a risk pool may contain 2 percent of outlays, but actual experience may have fewer-than-expected outliers, so that only half of the risk pool is used. A mechanism would, therefore, have to be developed to account for the annual shortages and surpluses that would accrue.

The accuracy of projections of outlier payments would be especially important for a large risk pool; that is, estimation of a threshold based on 25 percent of outlays would be more critical than one based on 2 percent of outlays. Since capitation payments would be lowered to fund the outlier pool, inaccuracies in the projections would be reflected in the capitation payments.

The effectiveness of an outlier payment policy depends on the level of the threshold. A policy based on a small percentage of outlays does not appear to reduce losses sufficiently, given the associated administrative burden of adopting it. As the threshold is lowered to capture a larger percentage of costs, the effectiveness of the policy increases, but the amount of care subject to capitation is reduced.

**Risk Corridors.** Risk corridors for profits and losses provide an alternative strategy for insuring against catastrophic losses. Instead of insuring against the costs of an individual, this approach considers the profits and losses for the plan as a whole. A large, profitable plan with a catastrophic loss would be unaffected by this policy, while a small one with overall losses would share the losses with Medicare. This approach would require each participating plan to provide a cost report at the end of each year.

In the Medicaid program, this policy is used successfully to insure specialized programs from large losses. The Medicaid program also shares large profits that may result either from successful health delivery strategies or from setting capitation payments too high. In the Medicare program, risk corridors might be adopted as part of demonstrations to encourage participation of specialized plans.

## **ADAPTING HEALTH CARE DELIVERY TO THE NEEDS OF VULNERABLE GROUPS**

The Commission's expert panel noted that some of the potential barriers to managed care are similar to those in fee for service, while others are unique to managed-care arrangements. Obstacles similar to those found in fee for service include cultural barriers, lack of transportation, and difficulty identifying appropriate physicians (e.g., an AIDS specialist).

Potential barriers identified as unique to managed care related to how some plans structure their health care delivery. These barriers include using gatekeepers, limiting choice of providers (especially specialists with particular types of expertise), failing to provide enough education about the plan's or the medical group's internal guidelines, and denying emergency services.



The panel also identified important strategies for restructuring health care to improve access and quality for vulnerable groups. These strategies include improving the coordination of care for enrollees, targeting services to particular populations, and identifying problematic cases. For better coordination of care, the panel suggested using primary care teams, providing case management, and collaborating with community agencies. It also suggested developing integrated data systems that include patient characteristics as well as clinical data, and making the data available to all providers.

The panel noted two strategies for targeting services to special populations. First, it recommended that the plan should identify any of its physicians who want to serve vulnerable patients and schedule appointments in a way that recognizes the heavier workload associated with caring for them. The panel also suggested that the plan provide health education specifically targeted to the individual's needs (e.g., foot care for diabetics instead of general advice like exercise and smoking cessation).

To keep vulnerable patients from getting lost in the system, the panel suggested establishing face-to-face contact during the first month of enrollment and identifying "missed opportunities," such as patients who show up in the emergency room or are readmitted to the hospital. Health plans should also provide aggressive follow-up, such as home visits for enrollees who cannot be reached by telephone. The panel also described strategies that would help enrollees negotiate the system of managed care. These strategies include providing grievance due process protection for enrollees and providers, expedited review, and an ombudsman program.

### **The Medicaid Experience**

The Medicaid program uses specific policies designed to improve health care delivery for vulnerable populations. These range from fostering a smooth transition into managed care and encouraging plans to maintain current provider relationships to increasing benefits for managed-care enrollees by promoting cost-effective care management.

The Prospective Payment Assessment Commission (ProPAC) contracted with Project HOPE's Center for Health Affairs to identify how state Medicaid programs ensure access to vulnerable populations enrolled in managed-care plans in seven states (Mark et al. 1995).<sup>7</sup> It found that states use an array of approaches. Some are applicable to all plan members and include specifying provider-to-population ratios; limiting travel time, time to obtain an appointment, and office waiting time; providing transportation; and requiring orientation to the plan for beneficiaries. Strategies that target specific subgroups include requiring contracting with community providers and multilingual informational materials and providers. Some states mandated requirements in extreme detail, while others' guidelines were more general.

Some states have adopted specific strategies to help integrate the most vulnerable Medicaid beneficiaries into managed-care plans. For example, Oregon's Medicaid program has developed a

---

<sup>7</sup> The states studied were Arizona, Florida, Maryland, Massachusetts, Minnesota, New York, and Oregon.

process to inform health plans in advance of patients' life-sustaining, ongoing treatment needs such as oxygen supplies. Delaware and Virginia require the plans to continue existing treatments or develop a transition for ongoing treatment needs (GAO 1996). As described earlier, screening and risk assessment also help facilitate a smooth transition into a managed-care plan. Arizona's Medicaid program requires plans to conduct a needs assessment of its disabled beneficiaries within 15 days of their enrollment, and provide a complete plan of care within 30 days or incur a financial penalty. Wisconsin requires case managers to perform a needs assessment within 55 days of enrollment, or the beneficiary is automatically disenrolled (GAO 1996).

Experience from the Medicaid program highlights the difficulty of developing and implementing new approaches and programs for vulnerable groups, although it can take longer than health plans expect as they build ties with community providers and social service agencies. It may also involve initiating contracts with specialists who serve particular vulnerable groups. As part of its review of risk-based programs for the disabled in Medicaid, the General Accounting Office (GAO) noted the importance of involving beneficiaries and advocates in planning and program design (GAO 1996).

Minnesota's Medica Health Plan of Allina Health System illustrates the challenges of developing and implementing new strategies for serving vulnerable populations. Medica Health Plan is an HMO that enrolls a wide range of vulnerable Medicaid subgroups, including children with special needs. To better accommodate these children, the plan worked with the State Health Department and the State Department of Human Services to assess the children's needs and determine what additional services they might require beyond those the plan typically offered. Part of the process of developing these services included convening multiple focus groups of providers, parents, advocates, and representatives from county government agencies. These focus groups helped identify problems that children with special needs had encountered in the past, potential barriers to receiving care, and future requirements.

Medica Health Plan also placed a priority on having these children maintain their existing provider relationships and giving them a choice of providers. To make certain the children's current providers would be available to them, the plan identified those providers recommended by advocacy groups who were not already under contract, and sought contracts with them. It also worked extensively to coordinate the provision of support services with county agencies and schools. Among the other steps Medica Health Plan took to improve access were developing models for personal-care-attendant services; providing non-emergency transportation; using nurse practitioners to coordinate care for specialty services; and furnishing bilingual staff, interpreters, and service providers.

Development of cost-effective care plans and case management afford the opportunity to expand benefits for vulnerable groups. For example, in the District of Columbia's Medicaid program for special needs children, a case manager—in collaboration with family, the primary care provider, and specialists—develops a six-month care plan for each child. The care plan eliminates the need for authorization of routine services and helps the program budget for services. This approach is also expected to provide more flexibility for problem solving, which in turn can prevent the cost of extraordinarily long hospital stays. By being able to ensure wheelchair access at home, for instance, an



inappropriate hospitalization can be avoided. Expected cost savings from this care planning strategy allow the plan to furnish additional benefits, including respite care, limited-use telephones, and non-emergency transportation.

Case management is also an important tool for coordinating the complex array of services required by vulnerable groups. Boston's Community Medical Alliance's programs for AIDS patients and the severely disabled greatly extends the role of their case managers. Nurse practitioners serve a dual role of clinician and care manager, setting up a full range of services and delivering some of the direct care themselves. This arrangement lets them respond more rapidly to patients' needs, because they can make decisions and initiate treatments more quickly, such as home respiratory therapy for an episode of pneumonia (Master 1996).

Grievance due process systems assume self-advocacy skills that may be difficult for vulnerable groups. Medicaid programs in Oregon and Wisconsin require health plans to have designated staff members who can function as advocates for disabled enrollees and their families. Oregon's Medicaid program also has a state-level ombudsman who plays a vital role in educating health plans on appropriate care for disabled members (GAO 1996).

### **Adapting Care Delivery in Medicare Managed Care**

In the Medicaid program, state agencies have often already developed an infrastructure for serving vulnerable groups by working directly with providers, and in some cases, by furnishing services directly. As a result, the state agencies can help plans identify the appropriate providers for these groups. They can also help plans coordinate the delivery of services with community service providers, schools, and other state agencies. The Medicare program does not, however, have comparable ties with providers and other agencies that serve the elderly, and therefore cannot readily help plans identify which ones are geared toward serving vulnerable groups.

New efforts to improve care for vulnerable groups in Medicare managed care emphasize case management and restructuring the delivery of care to meet the needs of those with chronic conditions. Case-management efforts may encompass early intervention, patient education, and helping the elderly access community services. The Community Resource Connection in Oregon, for example, conducts risk assessments for patients referred by participating primary care providers. On the basis of these assessments, the Community Resource Connection arranges for services like transportation, home-delivered meals, and home improvements (Levinson and Baxter 1996). Another program developed by Lovelace Health Systems in Albuquerque, New Mexico, stresses early intervention for chronic conditions such as diabetes, low back pain, breast cancer, stroke, and cardiac conditions. These case-management efforts emphasize prevention and patient education that allow the patient to avoid unnecessary hospitalizations or emergency room visits (Gunter 1996).

How case management is used in Medicare managed care varies across health plans. Pacala and his colleagues (1995) studied case-management practices in 17 large Medicare managed-care plans and



identified two types: high intensity with a low volume patients and low intensity with a high volume patients. High intensity case managers typically spend at least half of their time in direct patient contact and coordinate a broad range of services for enrollees. A little under half of the HMOs studied have programs that use this approach. Low intensity case managers, alternatively, make arrangements for their patients, but may not have any direct contact with them at all.

Another study of case managers in 23 HMOs identified six characteristics of effective case management: physician knowledge and acceptance of case management, teamwork, care planning, clear role definition, enrollee knowledge of case management, and support from upper management. Given the broad range of roles case managers can play, it is hardly surprising that case managers most commonly cite a lack of understanding of their role as a barrier to their effectiveness. Physicians who believe that case managers only try to save money for the plan are less apt to refer patients appropriately or early enough. Alternatively, some patients either fear case managers will prevent them from obtaining needed care or expect too much of them (Pacala and Boulton 1996).

An important component for serving vulnerable groups is restructuring how the care itself is delivered to meet their special requirements, especially for those with chronic illnesses. Current practices tend to be oriented toward acute illness, relying on patient-initiated visits and setting appointment priorities based on the urgency of symptoms. In addition, scheduled appointment times rarely allow providers enough time to serve the chronically ill.

A review of successful chronic care programs found that crucial features include adhering to an explicit plan or protocol, scheduling regular follow-ups, making systematic assessments, and encouraging self-management (Wagner 1996). In a Robert Wood Johnson Foundation study under way at the Group Health Cooperative of Puget Sound, an approach based on these principles is being developed for diabetic or geriatric patients. Every two to six months, a special half-day chronic care clinic is conducted for providers that includes assessment, education, and social support.

Vulnerable patients may have more difficulty than others in following treatment regimens and keeping track of scheduled visits. Provider-initiated follow-up may therefore improve the quality of their care. A study comparing provider initiated telephone calls with face-to-face clinic visits found that more frequent calling was more cost-effective than routine clinic visits. For patients in poor health, this approach was associated with improved physical functioning (Wasson et al. 1992). As part of its efforts to restructure clinic care for those with chronic illness, patients in Group Health Cooperative's study will receive interim follow-up telephone calls from their providers.

### **Promoting Innovative Approaches in Medicare Managed Care**

One of the challenging issues the Commission's expert panel recognized was identifying when vulnerable groups might benefit from special programs tailored to their needs and when enrollment in a traditional HMO might be preferred. At issue is the possibility that some vulnerable subgroups might be too few in number to support more than a single specialty risk contractor. That could lead to

“ghettos” of care, discouraging innovation, and leading to standards of care that are based on cost-cutting incentives.

By contrast, others are concerned that a traditional HMO may not be able to provide the full range of services needed by vulnerable persons, and that any underservice could not be monitored adequately because of the small number of those with special needs in a particular plan. Some problems might be identified through the grievance process or interviews with disenrollees; nonetheless some instances of underservice might remain undetected. In addition, patients with relatively rare conditions may be overlooked by empirically driven protocols and consequently have care denied as medically unnecessary (GAO 1996). Finally, some fear that, compared with their counterparts in special plans, vulnerable beneficiaries in traditional HMOs might be likelier to have to give up longstanding relationships with specialty providers who might not be in the plan’s network.

Medicare’s 50-50 rule, which requires that Medicare and Medicaid enrollees make up no more than 50 percent of a plan’s enrollment, would likely prevent specialized programs from contracting directly with the Medicare program except for demonstration purposes. Specialized programs could, however, subcontract with Medicare managed-care plans to provide care to special populations.

The Medicare program has limited avenues for promoting the diversity of approaches found in state Medicaid programs. Unfortunately, under current payment and risk arrangements, plans may be unwilling to offer services or access to special programs that might attract a larger share of costly or high-risk individuals. This, in turn, could postpone the development of innovative delivery systems for vulnerable subgroups until problems with payment methodologies and adequate risk adjustment are resolved.

To promote the development and evaluation of innovative strategies, HCFA should conduct demonstrations of alternative health delivery strategies for serving vulnerable groups in Medicare managed care. These demonstrations should provide flexible funding arrangements. While increased capitation payments and risk-sharing mechanisms may encourage Medicare managed-care plans to participate in demonstrations, other efforts may require start-up funding or loan guarantees.

Several difficult issues will continue to hinder development of policies to ensure access for vulnerable groups in Medicare managed care. For example, the current structure of Medicare benefits sets boundaries on what services managed care organizations can provide. Although some plans may find it cost effective to furnish additional benefits like preventive services and prescription drugs, other services like long-term care, social services, and additional mental health benefits are well beyond the reasonable scope of what plans can provide. The Social HMO and Program of All Inclusive Care for the Elderly (PACE) demonstrations offer beneficiaries a full array of benefits, including social services and long-term care, that go beyond the core benefit package. These programs must operate under demonstration grants, however, until broader issues concerning the benefit package are resolved.

Finally, little is known about the best practices for serving vulnerable Medicare beneficiaries in managed care. Lessons from the Medicaid program suggest that developing new services and restructuring delivery systems to accommodate vulnerable groups is challenging. Furthermore, concerns about proprietary information may make a health plan reluctant to share information about its successes, while apprehension about confidentiality might prevent disclosure of failures.

Despite these hurdles, some efforts to encourage dissemination of successful strategies are under way. The American Association of Health Plans, for example, has established the National Benchmarking Program, which identifies exemplary practices in its members' health plans. The program is focusing its efforts on management practices for breast cancer and low back pain at this time.

In Arizona, managed-care plans serving Medicare beneficiaries are collaborating to develop methods for assessing their own performance. Collaborative projects include studies of influenza, diabetes, mammography, depression, and benign prostatic hypertrophy. One medical director notes that collaboration makes it possible to conduct studies that a single plan would be unable to tackle alone because of limited resources and sample size. Another notes that earlier concerns about loss of strategic advantage were unwarranted given that improved outcomes may lead to more total members, and beneficiaries would likely choose among plans based on different styles of implementation (HSAG 1995).

To promote access for vulnerable groups, an agency such as Agency for Health Care Policy and Research (AHCPR) should develop a framework for research on effective strategies for serving vulnerable groups, coordinate public and private efforts to evaluate health delivery alternatives, and disseminate findings. This effort could ensure timely information about innovative approaches, protect plan confidentiality, provide technical expertise for evaluation design and analysis, coordinate research activities, and collect data useful for program development.

## REFERENCES

- Carter, Grace M., and Paul B. Ginsburg, *The Medicare Case Mix Index Increase: Medical Practice Changes, Aging, and DRG Creep*, The RAND Corporation, R-3292-HCFA, June 1985.
- Committee on Ways and Means, U.S. House of Representatives, *1994 Green Book: Overview of Entitlement Programs*, Committee Print 103-27 (Washington, DC: July 15, 1994).
- Cunningham, Robert, "Managed Care for Disabled: Big Hole in Medicaid Plan," *Medicine and Health Perspectives* 49(43):1-4, October 30, 1995.
- Echeverria, Cathryn, "Carving Out Selected Services for Children with Special Health Care Needs," presented at the Agency for Health Care Policy and Research conference on Providing Quality Services for Children with Special Health Care Needs Under Managed Care, July 23, 1996.



- Ellis, Randell P., Gregory C. Pope, Lisa I. Iezzoni, et al., *Diagnostic Cost Group (DCG) and Hierarchical Coexisting Conditions (HCC) Models for Medicare Risk Adjustment: Final Report*, Vol. I, report to the Health Care Financing Administration under Contract 500-92-0020 (Waltham, MA: Health Economics Research, Inc., April 1996).
- General Accounting Office, *Medicaid Managed Care: Serving the Disabled Challenges State Programs*, GAO/HEHS-96-136 (Washington, DC: July 1996).
- Gunter, Maggie, "EPISODES OF CARE Targets Chronic Conditions," *Chronic Care Initiatives in HMOs* (Washington DC: Group Health Foundation, March/April 1996).
- Health Services Advisory Group Inc., "Arizona Managed MediCare Quality Enhancement Program (AMMQEP)", *Pro-vider*, 6(2):1- 25, Summer 1995.
- Hornbrook, Mark C., and Michael J. Goodman, "Chronic Disease, Functional Health Status, and Demographics: A Multi-Dimensional Approach to Risk Adjustment," *Health Services Research* 31(3):283-307, August 1996.
- Horvath, Jane, and Neva Kaye, eds., *Medicaid Managed Care: A Guide for States*, second edition, (Portland, ME: National Academy for State Health Policy, 1995).
- Jones, Stanley B., "Why Not the Best for the Chronically Ill?," *Research Agenda Brief* (Washington, DC: George Washington University, January 1996).
- Kramer, Andrew, Peter Fox, and Nora Morgenstern, "Geriatric Care Approaches in Health Maintenance Organizations," *Journal of the American Geriatrics Society* 40(10):1055-1067, October 1992.
- Levinson, Wendy, and Elizabeth Baxter, "Beyond the Walls of the Doctor's Office: The Community Resource Connection," *Chronic Care Initiatives in HMOs* (Washington DC: American Association of Health Plans, November/December 1996).
- Mark, Tami, Ellen Bayer, Sharon Brooks, et al., *Medicaid Managed Care Program Access Requirements*, report to the Prospective Payment Assessment Commission under Contract T-99388296 (Bethesda, MD: Project HOPE Center for Health Affairs, March 1995).
- Master, Robert, Tony Dreyfus, Sharon Connors, et al., "The Community Medical Alliance: An Integrated System of Care in Greater Boston for People with Severe Disability and AIDS," *Managed Care Quarterly* 4(2):26-37, Spring 1996.
- Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series, No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).
- Newacheck, Paul W., and William R. Taylor, "Childhood Chronic Illness: Prevalence, Severity, and Impact," *American Journal of Public Health* 82(3):364-370, March 1992.

- Pacala, James T., and Chad Boulton, "Factors Influencing the Effectiveness of Case Management in Managed Care Organizations: A Qualitative Analysis," *Journal of Care Management* 2(3):29-35, June 1996.
- Pacala, James T., Chad Boulton, Kenneth W. Hepburn, et al., "Case Management of Older Adults in Health Maintenance Organizations," *Journal of the American Geriatrics Society* 43(5):538-542, May 1995.
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Riley, Gerald, Cynthia Tudor, Yen-pin Chiang, et al., "Health Status of Medicare Enrollees in HMOs and Fee-for-service in 1994," *Health Care Financing Review* 17(4):65-76, Summer 1996.
- Wagner, Edward, Brian T. Austin, and Michael Von Korff, "Organizing Care for Patients with Chronic Illness," *The Milbank Quarterly* 74(4):511-543, 1996.
- Wasson, John, Catherine Gaudette, Fredrick Whaley, et al., "Telephone Care as a Substitute for Routine Clinic Follow-up," *Journal of the American Medical Association* 267(13):1788-1793, April 1, 1992.
- Wrightson, C. William, James S. Genuardi, David R. McKusick, et al., *Actuarial Methods for Improving HCFA Payments to Risk HMOs: Final Report*, report to the Health Care Financing Administration under Cooperative Agreement No. 17- C-90033/3 (Annandale, VA: Actuarial Research Corporation, April 1996).





# Access to Care in Medicare Risk Plans

With total beneficiary enrollment in Medicare risk plans now at 11 percent and growing rapidly, the need to understand how beneficiaries fare in those plans is increasing. Interest by the Congress and the Administration in restructuring Medicare to provide more opportunities for beneficiaries to select prepaid health care arrangements further fuels the need for information. That interest also heightens the value of having access monitoring systems in place to alert policymakers to the effects of changes in the Medicare risk-contracting program.

Although both the Physician Payment Review Commission and the Health Care Financing Administration (HCFA) monitor access for beneficiaries in traditional fee-for-service Medicare, comparable information for evaluating the experiences and perceptions of those in the Medicare risk program is not available. Because Medicare pays plans for each enrollee rather than for each service provided, there are no complete and accurate claims data documenting the medical services received by enrollees. In addition, the Medicare Current Beneficiary Survey (MCBS), which provides comprehensive information on access, satisfaction, and utilization, has limitations in terms of its applications for Medicare managed care. The survey was designed to describe fee-for-service arrangements and, until the round administered in fall 1996, included too few managed-care enrollees to permit detailed analyses.

In response to this need for information, the Commission contracted with Mathematica Policy Research (MPR) to develop and field a survey of Medicare risk-plan enrollees and

*This chapter includes:*

- *Results from the most comprehensive, nationally representative study to date of access in Medicare managed care*
- *Implications of study findings for policymakers, researchers, and health plans*
- *Recommendations for monitoring access under Medicare managed care*

disenrollees on their access to care.<sup>1</sup> The study's goals were to obtain baseline information on beneficiary access in risk plans and, by identifying and documenting lessons learned in the process, to provide guidance about how this type of information might be collected regularly in the future. It represents the most comprehensive, nationally representative survey of access to care as viewed from the perspective of beneficiaries enrolled in or disenrolled from a Medicare risk plan. The study also showed the feasibility of collecting timely information valuable for the development of Medicare managed-care policy.

In light of the growing need and the demonstrated ability to collect information on access under Medicare managed care, the Department of Health and Human Services should monitor access in health plans participating in Medicare. A congressional agency should be required to analyze and comment on the Secretary's report on access to care in the Medicare risk program, just as the Commission now examines the Secretary's report on access under the Medicare Fee Schedule and suggests alternative approaches to analyzing access.

## *Recommendations*

*The Department of Health and Human Services should monitor access to care under health plans participating in Medicare and report annually to the Congress on enrollees' access. Monitoring efforts should be designed to permit comparisons, where possible, of access between Medicare managed care and fee for service.*

*Monitoring efforts should include analyses designed to explain access barriers for vulnerable groups and to determine the relationship between access and outcomes.*

Findings from the Commission's study were encouraging in most respects. Beneficiaries said they enrolled in risk plans because of the lower out-of-pocket costs and enhanced benefits they offered. Three-quarters paid no premium for their plan, and an even higher percentage received prescription drug benefits. More than 9 in 10 enrollees had obtained care through their plan within the previous year. The vast majority had no access problems and were satisfied with both their care and their plan. Nine in 10, for example, said they would recommend their plan to a friend or a family member. Only 8 percent had left their plans; more than half had switched to another risk plan rather than returned to fee for service. Nearly all new enrollees said they had received enough information to make them feel comfortable using their plan.

The study also revealed issues of potential concern, and areas in which plans could improve their efforts to facilitate beneficiary access. As is true in fee-for-service Medicare, certain vulnerable subgroups of risk-plan enrollees experienced access problems at rates significantly higher than their nonvulnerable counterparts. Disenrollees to fee for service, not surprisingly, also reported more access problems and

---

<sup>1</sup> The project was directed by Marsha Gold. The other principal investigators were Lyle Nelson and Randall Brown, and the survey was directed by Anne Ciemnecki.

were less satisfied than others. One in four persons who was currently in or who had left a risk plan would not recommend the plan to someone with a chronic or serious health problem. One in six who used home health care services said they did not get as many services as they needed. Finally, a third of enrollees were unaware of an important consumer protection: the right to appeal their plan's decisions about their health care.

This chapter summarizes the survey's key findings, drawing heavily on a report prepared for the Commission by MPR, and presents the Commission's conclusions regarding the study and its policy implications.<sup>2</sup> The chapter begins by briefly describing the survey's approach and design. It then presents the survey's findings on access to care for Medicare risk-plan enrollees overall. Next, it considers how results differ by enrollment status; for vulnerable groups; and among plans, markets, and regions. That is followed by comparing access in Medicare managed care with that under fee for service. The chapter concludes by discussing the study's implications for policymakers, researchers, and health plans.

## **SURVEY DESIGN AND METHODS**

The survey's design—particularly the development of the survey instrument—reflected a framework, developed for this study, that was designed to account for the various factors likely to affect access in a managed-care system. The framework showed that a wide variety of access measures need to be used to obtain a full picture of enrollees' access. The survey instrument therefore included sections on reasons for enrollment and disenrollment, experience obtaining care, satisfaction with care and with the plan, and beneficiary characteristics.

The population from which the survey's sample was drawn included all beneficiaries who were enrolled in a Medicare risk plan for at least two months during the year ending in February 1996. The sample was stratified by four categories of enrollment status: continuous enrollees (who made up 63 percent of the total population), new enrollees (29 percent), risk-plan switchers (5 percent), and disenrollees to fee for service (3 percent). A number of groups were oversampled to ensure representation sufficient for analysis, including African Americans, the nonelderly disabled, beneficiaries over age 85, disenrollees, and plan switchers. Beneficiaries from the five largest plans were undersampled to make estimates for those from small and medium-sized plans more precise.

Telephone interviews of 37 minutes' average duration were conducted with 3,080 Medicare beneficiaries between May and July 1996. The survey achieved a 64 percent response rate, which was lower than earlier surveys of this population, but comparable with other recent ones that had faced similar challenges in obtaining telephone numbers.

---

<sup>2</sup> The full report on the study's methods and findings, *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, by Lyle Nelson, Marsha Gold, Randall Brown, Anne B. Ciemnecki, Anna Aizer, and Karen A. Cybulski, was issued by the Commission in November 1996.



The survey was designed to allow for descriptive analysis of its findings. Analyses conducted included comparisons of access

- among subgroups of the beneficiary population, including analyses that grouped beneficiaries by enrollment status and that compared vulnerable groups with other beneficiaries;
- by type of plan, market, and region using administrative data from HCFA, market survey data from InterStudy, and data from the annual survey of health plans conducted by the industry's trade association;<sup>3</sup> and
- between risk-plan enrollees and beneficiaries in fee-for-service Medicare using data from the 1994 MCBS.

For analytical purposes, the survey data were weighted to represent the total beneficiary population enrolled during the study's time frame. In this chapter, the group called current enrollees includes new enrollees, continuous enrollees, and plan switchers. The term enrollees is used to describe the entire group of survey respondents (including current enrollees and disenrollees).

## **SURVEY FINDINGS ON ACCESS IN MEDICARE RISK PLANS**

This section describes the findings on access to care as it was measured in a variety of ways through the Commission's survey. The ability to characterize the survey results is limited by the lack of objective standards by which to evaluate many of the findings.

### **Enrollment and Disenrollment**

The reasons for Medicare risk-plan enrollment and disenrollment and the rates at which disenrollment occurs provide insight on beneficiary access to care.<sup>4</sup> The study revealed the aspects of risk plans that appealed to beneficiaries and the factors that led them to change their enrollment status.

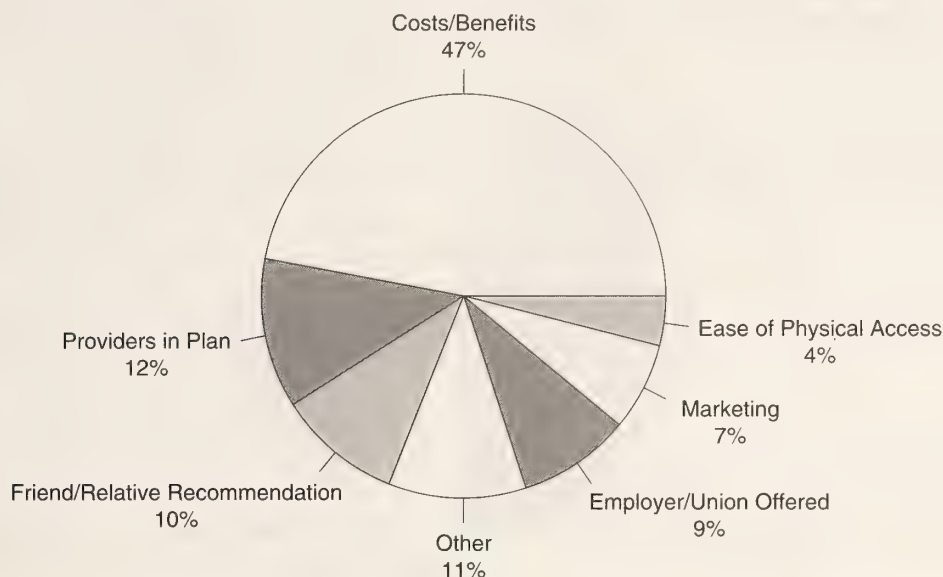
**Reasons for Joining a Plan.** Managed-care plans may facilitate access to care by offering a more expansive benefits package and lower out-of-pocket costs than beneficiaries have in traditional fee-for-service Medicare. Nearly half of all enrollees cited costs or benefits as their primary motivation for joining (Figure 6-1).

---

<sup>3</sup> The industry's trade association is the American Association of Health Plans, formerly known as the Group Health Association of America.

<sup>4</sup> Medicare beneficiaries have the opportunity to enroll in a managed-care plan at any time during the plan's open enrollment period. Many plans offer continuous open enrollment. In addition, beneficiaries have the option, at the end of any month, to disenroll from their plans to return to fee for service or to join another managed-care plan.

**Figure 6-1. Most Important Reasons for Enrolling in Medicare Risk Plans (percentage)**



**SOURCE:** Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

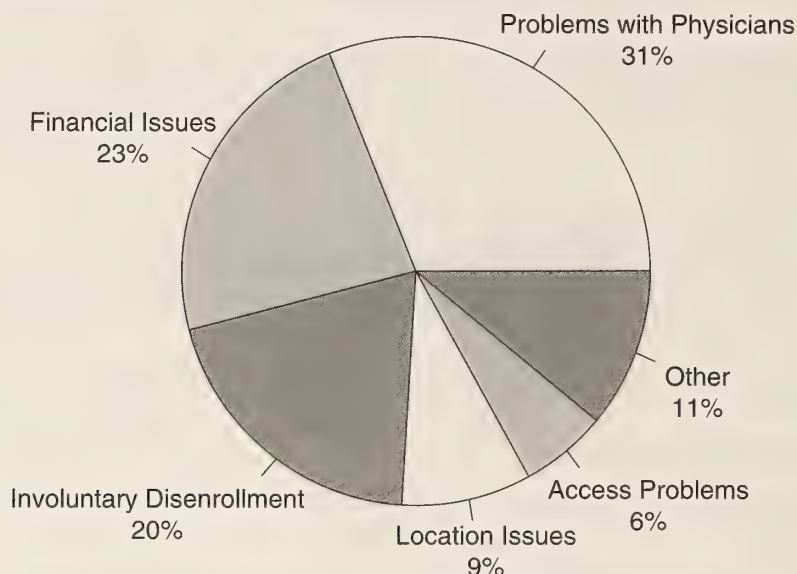
The relative importance of other reasons for enrolling in a risk plan varied by beneficiaries' enrollment status. For example, current enrollees were significantly more likely than disenrollees to say that providers were their primary motive for joining (12 percent versus 8 percent).<sup>5</sup> Beneficiaries who disenrolled were nearly twice as likely as current enrollees to report that a salesperson influenced their decision to join (11 percent versus 6 percent).

**Disenrollment Rates and Reasons for Disenrolling.** Only a small percentage (8 percent) of enrollees left their plans, and they did so for both voluntary and involuntary reasons (Figure 6-2). About a third of those who left their plans returned to fee for service. Of these beneficiaries, 36 percent left because of problems with their plan's physicians or access concerns, while 28 percent either moved out of their plan's service area or left for other involuntary reasons.<sup>6</sup> The reasons for switching plans differed from those for disenrolling. Plan switchers were more likely than disenrollees to have left their plan because their doctor left, died, or retired (10 percent versus 1 percent), and less likely to have left because of access problems (4 percent versus 10 percent).

<sup>5</sup> Beneficiaries whose enrollment was influenced primarily by providers included those who said they joined because their doctor was in the plan, those who wanted to use a doctor who was in the plan, and those who liked the plan's hospitals.

<sup>6</sup> In other words, 2 percent of enrollees voluntarily disenrolled from a risk plan and returned to fee-for-service Medicare.

**Figure 6-2. Most Important Reasons for Switching or Disenrolling from Medicare Risk Plans (percentage)**



**SOURCE:** Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

Disenrollment rates are an important indicator of satisfaction in a system that has a monthly disenrollment option, but some dissatisfied beneficiaries may delay or postpone this step. Four percent of current enrollees reported that they either planned to disenroll from their current risk plan or wanted to disenroll but felt they could not. The reason cited most often by the latter group was concern about their ability to obtain or afford a supplemental insurance policy.

### **Access**

Certain access measures used in the survey were designed to uncover beneficiary experiences that either fostered or impeded the ability to obtain care. The vast majority of enrollees responded positively to most items addressing experiences or features of their risk plans that were likely to promote access. A minority of enrollees had encountered one or more of the specific access problems about which they were asked.

**Factors That May Foster Access.** A variety of factors may serve to foster access in the managed-care environment. These include availability and affordability of services, continuity and coordination of care, and availability of information needed to negotiate the system of care.

**Costs and Benefits.** The survey's findings suggest that Medicare risk-plan enrollment provided increased benefits and lower costs, potentially reducing the financial barriers to care faced by some beneficiaries. Besides the influence of costs and benefits on beneficiaries' enrollment decisions, the



survey found that 76 percent of enrollees paid no premium for their plan and that 83 percent had outpatient prescription drug coverage, a benefit not provided under traditional Medicare.

**Availability.** Most enrollees had experience obtaining care through their plan. More than 9 in 10 enrollees said they had seen a plan doctor at least once within the previous year. A full 95 percent of those who were enrolled in their plan for at least one year reported having seen a plan physician in the past year. Only 5 percent had seen, during the past year, a physician who was not associated with their plan.<sup>7</sup> The most common reasons for doing so were the desire to use a physician who the beneficiary had used before enrolling (28 percent), the belief that plan physicians were not competent (20 percent), an effort to obtain care not covered by the plan (17 percent), and a belief that services could not be obtained quickly enough while in the plan (15 percent).

**Continuity of Care.** Medicare risk-plan enrollees reported favorable experiences with continuity of care. For example, 96 percent of enrollees were able to see the same physician for most scheduled visits within the past year. Furthermore, 42 percent of new enrollees and plan switchers said that upon their enrollment they kept the same primary care physician they had seen previously.

**Enrollee Information.** Whether or not enrollees have enough information to use their health plans can be an important determinant of the ability to obtain access to care. Of new managed-care plan enrollees, almost all—96 percent—reported receiving enough information from their plan upon their enrollment to make them feel comfortable. Plans appeared to do less well in meeting additional needs for information, however. Of the 25 percent who had a question or who wanted more information about their plan's services or benefits, one-fifth had problems or were unsuccessful in obtaining it. Similarly, while most beneficiaries said they knew they had the right to appeal if their plan refused to pay for or provide a service, nearly a third were unaware of their appeal rights.<sup>8</sup>

**Plan and Provider Initiatives.** As managed systems of care, risk plans can undertake a variety of initiatives to improve access to care. Given that experts recommend initial health screenings of new enrollees to ensure proper care management, the study's findings on beneficiaries' experiences in this area were disappointing. Only 38 percent of all new enrollees, and only 43 percent of those who also obtained a new physician, were encouraged by their plan or provider to have a physical examination or health assessment after they joined.

**Perceived Access Barriers.** Enrollees reported experiencing few access barriers. For example, 5 percent encountered delays in getting care while waiting for plan approval, 2 percent said their plan or physician lost or misplaced their medical record or test results, and 2 percent reported trouble communicating with their plan physician because of a language problem. In addition, few cited

---

<sup>7</sup> In responding to this question, beneficiaries were asked not to include care received while traveling outside the plan's service area.

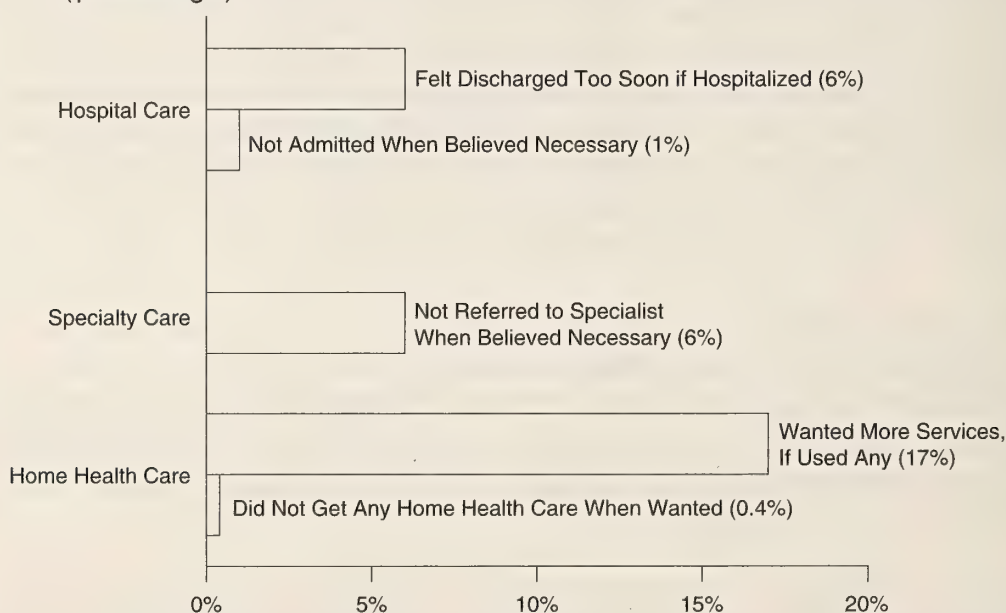
<sup>8</sup> This finding is consistent with a recent study by the Department of Health and Human Services Office of Inspector General, which found that 25 percent of enrollees were unaware of their appeal rights (OIG 1995).

problems with getting care at unusual times or places: 6 percent had difficulty getting care during the evening or on weekends, and 2 percent had a problem getting care while traveling away from home.

Enrollees were more likely to have problems making appointments and reaching their doctor by telephone. For example, 8 percent had trouble making medical appointments in their plan, and half of that group said they had trouble most of the time.<sup>9</sup> A quarter of those who had trouble making appointments said they had given up trying on one or more occasions. Additionally, 23 percent of enrollees said they had a problem reaching their primary care physician by telephone, although most characterized this problem as small.

**Access to Services.** Beneficiaries were asked about their experiences with hospital care, specialty referrals, and home health services (Figure 6-3). These are all areas in which anecdotal reports have suggested potential problems, or where problems might be expected to arise if an individual plan or provider responded inappropriately to incentives to constrain costs. The survey provides information on the extent to which beneficiaries did not receive care they wanted, but it does not address whether that care was medically necessary.

**Figure 6-3. Problems Obtaining Access to Services Among Medicare Risk Plan Enrollees (percentage)**



SOURCE: Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

<sup>9</sup> The type of trouble most often reported (by 59 percent of those who had any trouble) was that no appointments were available. Other problems among those who had trouble included busy phones or automated answering services (10 percent), being put on hold (9 percent), and available appointment times not being convenient (8 percent).

**Hospital Care.** Overall, 17 percent of enrollees had been admitted to a hospital in the past year while enrolled in their plan; of those, 6 percent said they were discharged from the hospital before they felt ready. Only 1 percent of enrollees said their plan physician failed to admit them to a hospital when they thought it was necessary. More than half of those who were not admitted to the hospital and more than two-thirds of those discharged before they were ready said that their health suffered as a result.

**Specialty Care.** Only 6 percent of enrollees said their plan physician failed to refer them to a specialist when they thought it was needed.<sup>10</sup> More than half (55 percent) of those not referred said the lack of referral was inconsequential, while another 14 percent said they had paid for specialty care out of pocket because they lacked a referral.

**Home Health Care.** Of the 8 percent who had used home health services while in their plan, 17 percent said they did not get as many services as they thought they needed. Less than 1 percent of enrollees said that they needed home health care but were unable to get any services through their plan. More than two-thirds of those who either did not get home health care, or who did not get as much care as they wanted, reported adverse consequences, including 24 percent whose conditions worsened and 8 percent whose recoveries were delayed.

## **Preventive Services**

The survey's findings were consistent with expectations about managed-care plans' focus on preventive care. For example, nearly half of those surveyed said their plan encouraged them to get preventive care, and one-third said their plan doctor did. The study also looked at whether Medicare managed-care enrollees had received six different types of preventive services in the past year: mammogram, flu shot, hearing test, glaucoma test, cholesterol test, and colorectal cancer screening. The results ranged from a low of 22 percent who had received a hearing test to a high of 71 percent who had received a cholesterol test.

## **Satisfaction**

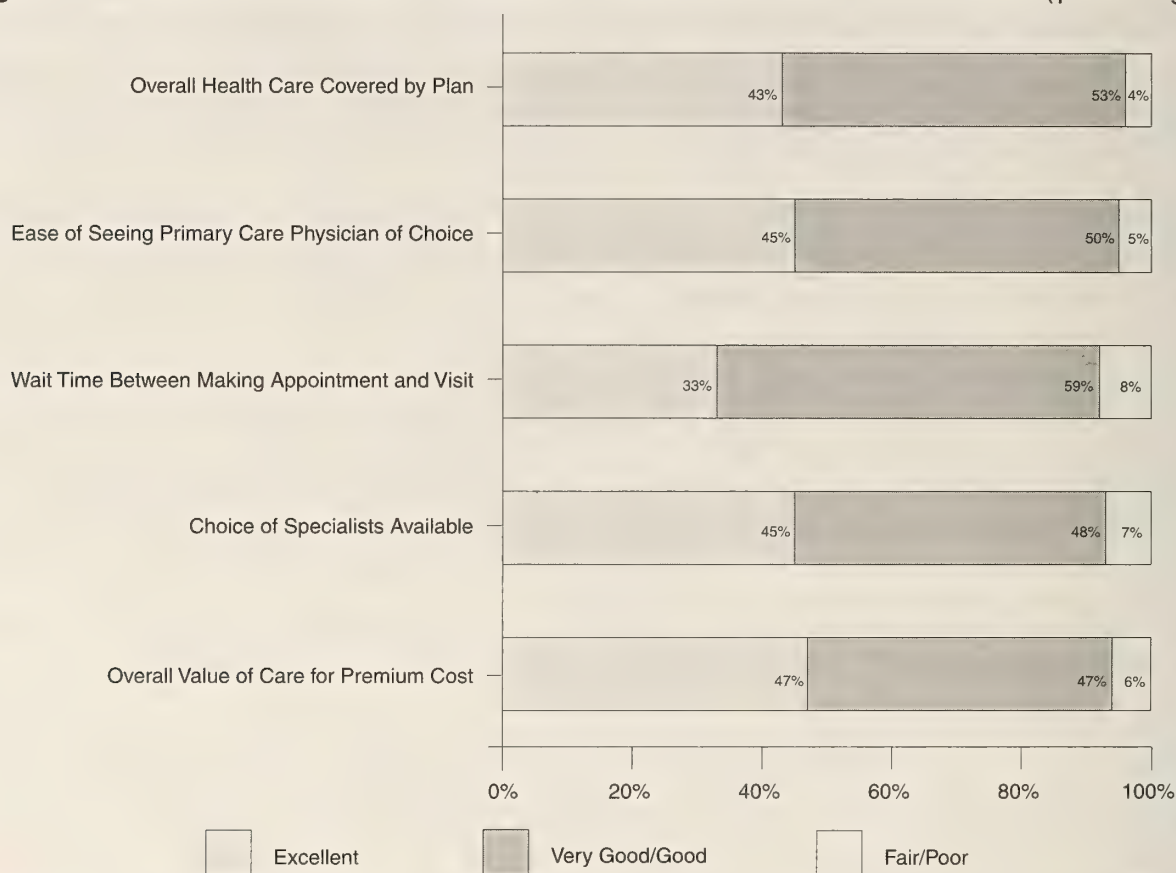
As with access, enrollee satisfaction was generally quite good. Ninety-one percent of enrollees would recommend their plan to friends or family members. That figure drops to 74 percent who would recommend their plan to someone who was seriously ill or who had a chronic condition, however. Nearly half of enrollees rated their plan's overall health care, the ease of seeing a primary care physician of choice, and the choice of specialists as excellent (Figure 6-4). Only 4 percent to 7 percent rated their plans as fair or poor on these dimensions, and only 6 percent rated the overall value of the care they received for the premium they paid as fair or poor.

---

<sup>10</sup> Half (51 percent) of risk-plan enrollees said that they had been referred to a specialist in the past year while in the plan.



**Figure 6-4. Selected Measures of Satisfaction for Medicare Risk Plan Enrollees (percentage)**



**SOURCE:** Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

## **SURVEY RESULTS FOR GROUPS OF BENEFICIARIES AND PLANS**

To gain further insights from the study, comparisons of access and satisfaction for groups within both the beneficiary and risk-plan populations were made. The findings were analyzed by beneficiary enrollment status to identify differences and similarities among new enrollees, continuous enrollees, disenrollees, and switchers. Vulnerable subgroups of the beneficiary population were examined to identify the characteristics that were associated with differential access. Differences among plan types, markets, and regions were also explored.

### **Access and Satisfaction by Enrollment Status**

Although disenrollees and plan switchers constitute only a small percentage of the total population covered by the survey, they are an interesting group from a policy perspective. In terms of access and satisfaction, those who leave their plan to join another and those who disenroll to fee-for-service

Medicare were dissimilar. Health plan switchers were, by most access and satisfaction measures, more similar to continuous enrollees or new enrollees than they were to disenrollees. Disenrollees to fee for service, on the other hand, differed significantly from current enrollees in most respects.

As a group, disenrollees had more access problems and were less satisfied than current enrollees. They were about twice as likely to report most types of access problems. For example, 15 percent cited trouble making appointments, compared with 8 percent of current enrollees. They were about half as likely as current enrollees to rate the overall health care provided by their plan as excellent, and were six times as likely to rate it fair or poor. Not all disenrollees were dissatisfied with their plan, however. More than half—57 percent—would recommend their former plan to family or friends, although that figure drops to 44 percent who would recommend it to someone with a serious or chronic health problem.

### **Access and Satisfaction for Vulnerable Beneficiaries**

The findings on access were also considerably less positive for some vulnerable groups of beneficiaries. Those with higher rates of access problems than their counterparts included the nonelderly disabled, the oldest-old (those over age 85), the functionally impaired, those in fair or poor health, and those in worsening health (Table 6-1). Many of these groups also had higher-than-average disenrollment rates, including the functionally impaired (6 percent) and the nonelderly disabled (5 percent).

To explore the issue of whether vulnerable groups experienced more access problems solely because they had greater needs for care (and thus more opportunities to encounter problems), the study also looked at the rates of access problems among only those who had either used or wanted to use a particular service. In most cases, greater need for care explained much of the difference in rates of access problems between vulnerable groups and their nonvulnerable counterparts.<sup>11</sup> The nonelderly disabled stood out in this analysis in that differences in health care needs did not account for this group's problems. Even after adjustments, these beneficiaries remained twice as likely as those in the 65-to-84 age group to have had difficulty obtaining home health care or specialty referrals.

The groups of enrollees experiencing more access problems were not, for the most part, those reporting lower satisfaction. African American beneficiaries, for example, reported significantly lower satisfaction than white beneficiaries, but did not experience a higher rate of access problems. Another interesting finding was that those groups who had more access problems or who were less satisfied were just as likely as others to say they would recommend their plan to someone with a serious or chronic health problem. Thus it appears that vulnerable beneficiaries were no more inclined than their nonvulnerable counterparts to see fee-for-service Medicare as a better option for those likely to have higher-than-average needs for health care.

---

<sup>11</sup> This was particularly true for home health services, where the greatest relative rates of problems arose. Adjustment for need had a lesser impact on the differences between vulnerable and nonvulnerable groups in the rates of access problems for specialty care and hospital care.

**Table 6-1. Selected Access Measures for Medicare Risk-Plan Enrollees, by Vulnerable Subgroup (percentage)**

	All Beneficiaries	Non-elderly Disabled	Over Age 85	African Americans	In Fair or Poor Health	In Worse Health Than a Year Ago	With a History of Cancer, Heart Disease or Stroke	Functionally Impaired
Not referred for specialist care enrollee thought was needed	6.2	9.5	*	*	*	11.4	*	*
Not admitted to hospital when enrollee thought was needed	1.4	3.4	3.3	*	3.8	3.1	*	3.7
Felt discharged too soon if hospitalized	6.2	*	*	*	*	*	7.2	13.2
Did not receive home health care enrollee thought was needed	1.6	4.1	5.4	*	5.6	6.4	2.5	7.6
Experienced delays while waiting for plan approval	4.8	10.8	*	2.7	9.3	11.7	6.1	8.2

SOURCE: Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

\* No statistically significant difference between vulnerable group and reference group at .05 level. Reference groups were those ages 65 to 84 (for the nonelderly disabled and those over age 85), whites (for African Americans), those in excellent health (for those in fair or poor health), those who said their health status was the same as last year (for those in worsening health), those with no history of cancer, heart disease, or stroke (for those with a history of any of these medical conditions), and those without functional impairments (for the functionally impaired).

### Access Differences across Plan Types, Markets, and Regions

The study found no large or consistent differences in access or satisfaction across different types of plans or market areas. No regional or state-specific patterns were discernable, for example, nor were they found by looking at the size, model type, or tax status of plans. The experiences and perceptions of beneficiaries in plans in which Medicare enrollment accounted for less than 10 percent of total enrollment were similar to those in plans where Medicare represented 20 percent or more. In addition, findings for enrollees who paid no premium for their plans were comparable to those for enrollees who did pay a premium.

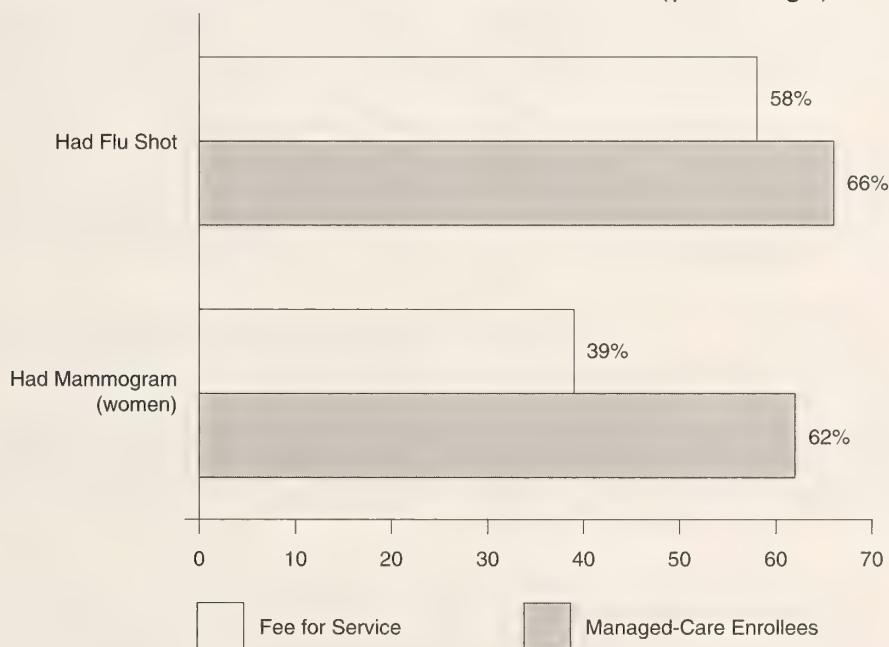


## COMPARISONS WITH ACCESS IN FEE-FOR-SERVICE MEDICARE

Some comparisons with fee-for-the-service Medicare were made where it was possible using data from the Medicare Current Beneficiary Survey, but differences in access measures used and in survey design complicate the comparisons.<sup>12</sup> In design of the Commission's study, some items from the MCBS were included. But because the study's objective was to develop the best possible information on Medicare managed care, fee-for-service comparability was secondary.

With respect to preventive care, Medicare risk plans compared favorably with fee for service (Figure 6-5). Comparable information on fee-for-service enrollees was available for only two services, flu shots and mammograms. A full 62 percent of female Medicare risk-plan enrollees reported having received a mammogram in the past year, compared with only 39 percent of those in fee for service.<sup>13</sup> Of those in Medicare risk plans, 66 percent had a flu shot for the previous winter, as opposed to 58 percent of those in fee for service.

**Figure 6-5. Use of Preventive Care in Medicare in Past Year (percentage)**



**SOURCE:** Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

<sup>12</sup> Where comparisons were made, data on beneficiaries in fee for service were adjusted for age, sex, and race to account for differences from the population enrolled in risk plans. In addition, only those fee-for-service beneficiaries who resided in an urban area were included in the analysis, because nearly all of risk-plan enrollment is urban.

<sup>13</sup> To adjust the mammography rates, beneficiaries were grouped in three age categories: under age 65, 65-to-84, and over age 85. The substantial difference between risk plans and fee for service in mammography rates may be partly explained by differences in the distribution of women within the 65-to-84 age group, since some guidelines do not recommend mammograms for women after age 75.

Although the comparability of rates of access problems is less clear, beneficiaries in risk plans appear to have had more access problems than those in fee-for-service Medicare (Table 6-2). Twelve percent of risk-plan enrollees said that, in the past year, they had experienced at least one of six different access problems, such as delays obtaining care while waiting for plan approval. By contrast, the MCBS asks a single, global question about whether the beneficiary has had any trouble getting care within the past year; 4 percent of beneficiaries in fee for service reported that they had. Because of differences in how access problems were assessed in the two surveys, the difference between fee for service and risk plans is likely to be overstated by this analysis. Nonetheless, the difference seems to be too large to be entirely explained by differences in methodology (Nelson et al. 1996).

**Table 6-2. Access Problems Experienced by All Beneficiaries and by Vulnerable Subgroups in Medicare Risk Plans and Fee-for-Service Medicare (percentage)**

	All Beneficiaries	Nonelderly Disabled	Over Age 85	African Americans	Low Income <sup>a</sup>	Fair or Poor Health
Fee-for-Service Beneficiaries <sup>b</sup>	4.0	14.1	3.1	8.2	7.8	9.3
Risk-Plan Enrollees <sup>c</sup>						
All enrollees	13.3	24.9	16.1	12.6	15.9	23.6
Enrolled for one year or less	12.0	21.3	23.1	13.6	16.5	26.1

SOURCE: Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

<sup>a</sup> Low income is defined as an annual household income of less than \$10,000.

<sup>b</sup> For fee-for-service beneficiaries, the access measure shown is the percentage who reported having trouble getting health care they wanted or needed within the past year.

<sup>c</sup> For risk-plan enrollees, the access measure shown is the percentage who reported one or more of the following problems since enrolling in the plan: not being referred for specialist care wanted, not being admitted to a hospital when wanted, being discharged from a hospital before feeling ready, not receiving home health care wanted, experiencing delays obtaining care, and experiencing any other problems obtaining care.

Although beneficiaries in risk plans may have higher rates of access problems, the differences between vulnerable beneficiaries and others appear to be generally smaller in risk plans than they are in fee for service (Table 6-3).<sup>14</sup> For example, disabled beneficiaries in fee for service were five times as likely as their nondisabled counterparts to have had any access problems. In managed care, disabled beneficiaries were twice as likely as the nondisabled to have had problems. This finding was particularly interesting for African Americans, who were twice as likely as white beneficiaries to have had access problems in fee for service, but were slightly less likely than whites to have had any problems in managed care.

<sup>14</sup> See Chapter 14 for discussion of access for vulnerable groups in Medicare fee for service.

**Table 6-3. Access Problems Experienced by Vulnerable Subgroups Relative to Their Counterparts, in Medicare Risk Plans and Fee for Service (ratio)**

	Nonelderly Disabled	Over Age 85	African Americans	Low Income <sup>a</sup>	Fair or Poor Health
Fee-for-Service Beneficiaries <sup>b</sup>	5.2	1.1	2.4	3.9	11.6
Risk-Plan Enrollees <sup>c</sup>					
All	2.0	1.3	0.9	1.3	2.2
Enrolled for one year or less	2.1	2.2	1.2	1.9	4.5

SOURCE: Survey of Medicare risk-plan enrollees and disenrollees sponsored by the Physician Payment Review Commission (Nelson et al. 1996).

<sup>a</sup> Low income is defined as an annual household income of less than \$10,000.

<sup>b</sup> For fee-for-service beneficiaries, the access measure shown is the percentage who reported having trouble getting health care they wanted or needed within the past year.

<sup>c</sup> For risk-plan enrollees, the access measure shown is the percentage who reported one or more of the following problems since enrolling in the plan: not being referred for specialist care wanted, not being admitted to a hospital when wanted, being discharged from a hospital before feeling ready, not receiving home health care wanted, experiencing delays obtaining care, and experiencing any other problems obtaining care.

NOTE: The ratio is the proportion of the subgroup with access problems divided by the proportion of the counterpart (or reference) group with access problems. The reference groups are: beneficiaries ages 65 to 84 (for comparison with the nonelderly disabled and those over age 85), whites (for African Americans), those with an annual household income over \$20,000 (for those with low income), and those in excellent health (for those in fair or poor health).

## STUDY CONCLUSIONS AND IMPLICATIONS OF RESULTS

The primary purpose of the Commission's study was to develop and test measures of access and survey methodology for the Medicare risk program so that information on access could be collected regularly in the future. A secondary purpose was to collect baseline data that could be used as a point of comparison with that from future access studies. These initial findings did suggest areas for future attention, however.

### Conclusions Regarding the Study of Access in the Medicare Risk Program

The study demonstrated the feasibility of using beneficiary survey information to evaluate access to care in the Medicare risk program. The Commission was able to obtain timely data on a variety of aspects of enrollees' experiences and perceptions that offered a rich, multidimensional view of access to care. Survey data were used to identify both the types of access problems that occurred and the groups most likely to experience them. No differences were found by characteristics of plans, markets, or regions, although it is not clear whether this is due to limitations in the available classifications or to



lack of variation in access by these characteristics.<sup>15</sup> The study did not examine use of other types of information, such as clinical or encounter data, to evaluate access in the Medicare risk program. In conjunction with survey data, these other types of data offer the potential to provide a richer perspective on access by permitting analysis of the relationships between perceived access, the provision of appropriate services, and health care outcomes.<sup>16</sup>

The study also underscored the need for comparable data on access for beneficiaries in fee-for-service and managed-care systems. Access measures that are meaningful for both types of delivery systems should form the basis of comparisons.<sup>17</sup> Such measures could be used to identify the relative strengths and weaknesses of each type of delivery system for ensuring access to care. This information could help beneficiaries make appropriate choices and could serve to inform decisions regarding Medicare program policy.

### **Implications of Key Findings from the Survey**

The study's results suggest a number of issues for attention by policymakers, researchers, and health plans. Findings relevant for considering changes in Medicare risk program policy are reviewed first. This is followed by discussion of findings that suggest additional work is needed both to understand the causes of certain problems and to design policies to address them.

Although limitations in the ability to draw comparisons between Medicare managed care and fee for service make firm conclusions impossible, the study's findings suggest that some risk-plan enrollees are making trade-offs between unrestricted access and increased benefits. Some beneficiaries may now choose to accept restrictions on access—even those that they perceive to be problematic—in exchange for increased benefits and lower costs that could foster access in another respect.<sup>18</sup> While this trade-off may not affect health outcomes, it should be taken into account as the Congress considers changes in plan payment that might affect plans' ability to provide increased benefits or lower costs for their enrollees.

The study's findings also have implications for disenrollment policy. The study found a relatively low disenrollment rate for the risk program overall, although other analyses have shown disenrollment rates to vary widely among plans (GAO 1996). Many of those leaving one risk plan for another seem to be

---

<sup>15</sup> It may be that there are differences in beneficiary access across plans, but that these differences are not correlated with particular characteristics of plans, markets, or regions.

<sup>16</sup> See Chapter 8 for discussion of the types of managed-care data that could be useful for access monitoring, quality assurance, and risk adjustment.

<sup>17</sup> Additional measures that are targeted to the type of delivery system can also be used to obtain information that is not usefully compared between the two systems.

<sup>18</sup> Brown and his colleagues (1993) found that risk enrollees appeared willing to trade-off satisfaction for lower out-of-pocket costs and better benefits. Findings from the risk-program evaluation showed that risk enrollees were less likely than fee-for-service beneficiaries to rate their care as excellent, yet 92 percent said they would recommend their plan to a friend or relative.

opting for better benefits, lower costs, or a more convenient location. Moreover, a significant percentage who disenroll or switch plans do so involuntarily, for example, because they move or their plan drops its Medicare contract. But many of those who leave their plans or the risk program do so because they are dissatisfied or have experienced problems.

The Commission's study confirms that, as in fee for service, certain subgroups of beneficiaries are vulnerable to access problems in managed-care delivery systems. This finding suggests that the potential of managed care to implement innovative solutions to the access problems of vulnerable groups has yet to be tapped and that further exploration of how to meet the health care needs of vulnerable populations is needed.<sup>19</sup> In addition, the findings suggest the need to explore further the differences in rates of access problems among groups and the factors that contribute to these problems. The nonelderly disabled, whose access problems were not explained by differences in the need for care, warrant particular attention because they account for a growing share of Medicare risk enrollees.

Home health care is another area for further examination illuminated by the study. Higher rates of unmet demand for these services relative to others may, in part, reflect raised expectations for use of these services associated with exponential growth of home health care in fee-for-service Medicare. Additional investigation is needed, however, because another study showed that outcomes are poorer and episodes of home health care are shorter in managed-care plans relative to fee for service (Shaughnessy et al. 1994).

Finally, the study suggested that plans could improve their efforts to provide information to enrollees. Although plans appear to meet new enrollees' immediate needs for information, consumer protection could be enhanced by meeting more of enrollees' subsequent information needs and by taking additional steps to inform enrollees of their appeal rights. Consumer information is likely to be an issue in fee-for-service Medicare as well, although there are no data by which to estimate the extent of the problem.

## REFERENCES

- Brown, Randall S., Jeanette W. Bergeron, Dolores G. Clement, et al., *The Medicare Risk Program for HMOs—Final Summary Report on Findings from the Evaluation* (Princeton, NJ: Mathematica Policy Research, Inc., February 1993).
- General Accounting Office, *Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance*, GAO/HEHS 97-23 (Washington, DC: October 1996).
- Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series, No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).

---

<sup>19</sup> See Chapter 5 for discussion of how access to care for vulnerable groups might be fostered in Medicare managed care.

Office of Inspector General, Department of Health and Human Services, *Beneficiary Perspectives of Medicare Risk HMOs*, OEI-06-91-00730 (Washington, DC: March 1995).

Shaughnessy, Peter W., Robert E. Schlenker, and David F. Hittle, "Home Health Care Outcomes Under Capitated and Fee-for-Service Payment," *Health Care Financing Review* 16(1):187-221, Fall 1994.



# Using Quality and Performance Measures in Medicare

The growing use of information on the performance of health plans and the quality of care they furnish increases the potential for using comparable data in the Medicare program. In previous annual reports, the Physician Payment Review Commission recommended that information on the performance and quality of care of health plans participating in Medicare be collected and provided to beneficiaries to promote value-based competition among plans (PPRC 1995; PPRC 1996). It also recommended that Medicare build on private-sector efforts to minimize the burden that these activities would place on plans.

The Commission is encouraged by the considerable recent progress in this area made by the Health Care Financing Administration (HCFA). The agency has taken steps to begin collecting information on the performance of health plans participating in Medicare, which serve a relatively small but rapidly growing number of beneficiaries. It has produced Medicare quality measurement and reporting requirements for participating health plans and has indicated that it expects to provide information on plan performance and health care quality to beneficiaries in the near future. In its efforts, HCFA has worked closely with private-sector leaders in health plan performance and quality measurement, avoiding duplication of effort and promoting standardization in measurement approaches.

How information on health plan quality and performance will be used in the Medicare program will be determined by both political and technical considerations. Quality and performance

*This chapter includes:*

- *HCFA's plans to collect new information on quality and health plan performance*
- *Uses for quality and performance information in Medicare*
- *Eliminating the 50-50 rule for Medicare plans concurrent with quality system enhancement*

measures could be used to enhance many aspects of Medicare's quality system, including quality improvement efforts and program monitoring. Such measures could also be used in new quality assurance strategies, such as beneficiary-oriented performance reporting. As these performance measures become an integral part of Medicare's quality assurance program, opportunities are presented to reconsider the quality system as a whole and the effectiveness of its components. Policies that were developed when such measures were not available should be subject to reevaluation.

## *Recommendations*

*Performance measures should be used now in Medicare to provide beneficiaries with information on participating health plans and, where comparable information can be obtained, on fee for service. The measures should also be used in Medicare's quality improvement program and in program monitoring.*

*The Health Care Financing Administration (HCFA) should proceed in its use of Medicare performance measures as guided by advances in methodology and by considerations of public acceptance and private-sector use. HCFA should continue to collaborate with others to identify core measures to promote efficiency and minimize duplication of effort.*

*The enrollment composition requirement (50-50 rule) should be dropped concurrent with implementing an enhanced quality assurance system that incorporates health plan performance measures. Plans should participate in an audited system of consumer-oriented performance reporting, maintain an internal quality assurance program, and be subject to external quality review by an independent entity approved by the Department of Health and Human Services.*

HCFA should continue to work closely with others in the public and private sectors to refine approaches for using information to improve quality and to inform or protect beneficiaries. The agency should also take a leadership role in pursuing innovative strategies for presenting information to beneficiaries in formats that facilitate its use. As a public program, HCFA's efforts in this area could provide models for other purchasers or health plans seeking to inform consumers about their options for health care arrangements.

This chapter presents the rationale underlying the Commission's recommendations for use of performance measures in Medicare. It first provides an overview of HCFA's plans for collecting new information on the quality of care and performance of Medicare plans. It then describes factors that must be considered in determining how the information could be used in Medicare, and lays out various approaches for doing so. The chapter concludes by pointing out other issues to be addressed in implementing specific strategies for using performance measures.

## MEDICARE PLAN PERFORMANCE AND QUALITY MEASURES

New reporting requirements will substantially increase the amount of information on quality of care, health plan performance, and enrollee satisfaction that is available for administering the Medicare risk-contracting program. This section describes the information now used and the types of data that are expected to be available in the future.

### Current Plan Performance and Quality Data in Medicare

Information on Medicare health plans' performance and quality of care is used in three specific aspects of program oversight. First, it is used in plan-specific evaluations to determine compliance with Medicare participation requirements. It is also used by the regional quality improvement organizations (QIOs), as part of the Medicare quality program.<sup>1</sup> Finally, this information provides the basis for the Medicare managed-care program monitoring capability.

To date, the information that has been available for these purposes has been quite limited, however. HCFA evaluates participating health plans' compliance with structural and organizational requirements, but has few specific standards for performance or quality of care.<sup>2</sup> Some information is available on rates of enrollment and disenrollment and on beneficiaries' grievances and appeals. Although QIOs collect some data on the quality of care in specific clinical areas, the clinical areas that are studied vary. Because QIO performance information is not uniformly collected, it could not be used to compare plans, and it is not systematically considered by HCFA in evaluating plans' performance.

Other types of information that could be used for quality and performance measurement have not been available or have been inadequate. Because risk plans are paid on the basis of their enrollment rather than for services provided, for example, HCFA does not have claims data that would supply information on the services used by beneficiaries in these plans.<sup>3</sup> Survey data on beneficiaries' experiences and perceptions regarding their health plans have also been limited. The Medicare Current Beneficiary Survey, which provides comprehensive information on beneficiary access, utilization, and satisfaction, is geared toward fee-for-service arrangements and does not cover issues relevant to managed care. Until the round administered in the fall of 1996, it included too few managed-care plan enrollees for many types of analyses that would be desirable, such as studies of vulnerable subgroups of beneficiaries.

---

<sup>1</sup> Quality improvement organization is the new term for the entities formerly known as peer review organizations. The name was changed to reflect recent changes in the functions and role of the organizations in promoting quality of care. Peer review organizations focused on the identification of individual episodes of substandard quality care. The QIOs now collaborate with providers to develop and implement quality improvement projects in specific clinical areas.

<sup>2</sup> For example, plans must be federally qualified health maintenance organizations or competitive medical plans, plans' enrollment of Medicare beneficiaries may not exceed 50 percent of total enrollment, and plans must maintain quality assurance programs that stress health care outcomes and incorporate peer review.

<sup>3</sup> Hospitals are required to submit so-called no-pay bills on behalf of their Medicare managed-care patients, but in practice often fail to do so. See Chapter 8 for discussion of the capabilities of health plans to provide various types of data.



## New Information Expected on Plan Performance and Quality

As the result of a number of recent Medicare program initiatives, several types of data on the performance of participating health plans are expected to become available in the near future.<sup>4</sup> First, beginning this year, plans must report information on the health care provided to Medicare beneficiaries, using the Medicare measures from version 3.0 of the Health Plan and Employers Data and Information Set (HEDIS).<sup>5</sup> In addition, plans' enrollees will be surveyed on their satisfaction, using an instrument developed for the Medicare population as part of the Agency for Health Care Policy and Research's Consumer Assessments of Health Plans Study. Finally, HCFA expects to use a set of outcomes measures developed by the Foundation for Accountability (FACct), an organization composed of public and private health care purchasers and consumer groups, to obtain information on care provided through both managed-care and fee-for-service arrangements.<sup>6</sup>

**Development and Use of HEDIS Measures.** HEDIS 3.0, issued in early 1997 by the National Committee for Quality Assurance (NCQA), includes measures of health plan performance and specifications for the provision of descriptive information in eight domains: effectiveness of care (quality), access, member satisfaction, plan stability, service use, costs of care, outreach/member information services, and plan characteristics.<sup>7</sup> Version 3.0 is the first to provide quality measures designed for the elderly and disabled Medicare populations.

HEDIS is recognized as the state of the art in health plan performance measures. The development of HEDIS 3.0 involved experts in health plan performance and clinical quality measurement as well as representatives of health plans, public and private purchasers, and consumers. Performance measures for potential inclusion in HEDIS 3.0 were solicited from more than 1,700 organizations, yielding a total of 826 measures submitted. The measures were selected based on scientific soundness, feasibility, and relevance to interested parties.

Use of HEDIS measures by health plans and purchasers is now widespread and continues to grow. A 1994 Commission-sponsored survey of managed-care plans found that three-quarters of health

---

<sup>4</sup> The Commission supports the collection of information on quality of care and health plan performance, but believes that beneficiary-level data is also vital to support quality assurance strategies, access monitoring, and risk adjustment of payments to health plans. See Chapter 8 for additional discussion of data needs and rationale for the Commission's recommendation that HCFA develop a core health data set to be provided by the health plans participating in Medicare and their contractors.

<sup>5</sup> Seven measures included in HEDIS 3.0 were developed specifically to address the health care provided to Medicare beneficiaries. These include six measures of the processes used in providing care: flu shots, breast cancer screening, beta blocker treatment after heart attacks, eye examinations for diabetics, followup after mental illness hospitalizations, and the provision of smoking cessation advice. One outcome measure, designed to evaluate the change in elderly beneficiaries' health status over time, is also included.

<sup>6</sup> The measures address outcomes for treatment of breast cancer, diabetes, and depression.

<sup>7</sup> The reporting set of HEDIS 3.0 consists of a total of 74 measures and specifications for descriptive information. Another 30 items make up a testing set that will be considered for future versions of HEDIS. Some of the HEDIS 3.0 measures apply to all plan enrollees and others are specific to plans' Medicare, Medicaid, or commercial enrollees.

maintenance organizations had estimated HEDIS measures for their own internal use or in response to a purchaser request (Gold et al. 1995). NCQA now reports that more than 330 managed-care plans have used HEDIS and that a majority of large employers now use it to assess plans (NCQA 1996). In August 1996, NCQA released its first Quality Compass, a performance report providing 1995 HEDIS 2.5 performance measures and accreditation status for 226 health plans.<sup>8</sup> This product makes information on health plan performance available to interested parties, including small employers that may find it inefficient to collect such information on their own.

Health plans, employers, and purchasing groups are using HEDIS performance measures for a variety of purposes. The quality measures have been used by plans in their internal quality assurance programs. HEDIS measures have served as the basis of many performance reports issued by plans for their purchasers or for consumers, or by employers to help their employees select among plans.<sup>9</sup> Finally, employers increasingly use HEDIS performance information in administering their benefits programs, for example, in making contracting decisions or, as in the case of GTE, by providing incentives for employees to select high-performing plans.

**Enrollee Satisfaction Survey.** In addition to the HEDIS information on health plan quality and performance, HCFA also expects to obtain information on beneficiaries' satisfaction with their plans. Beginning this year, the agency intends to contract with an external organization to conduct the first of what is planned to be an annually administered survey of between 500 and 700 enrollees in each Medicare managed-care plan. The survey instrument includes questions on quality of care, access to care, and utilization of services. Developed as part of a larger project to obtain comparable information on public and private health plan enrollees, the survey includes a core set of questions and supplemental items designed for Medicare beneficiaries, Medicaid beneficiaries, and the chronically ill or disabled.

**Outcomes Measures for Medicare.** The use of outcomes measures to evaluate quality of care is advocated by many because these measures focus on the results of care provided rather than the means for achieving those results. HCFA recently awarded a four-year contract to RAND to refine and test the outcomes measures for Medicare developed through FAcct. In the first phase of the contract, RAND will work with FAcct members to convene expert clinical panels to review and refine the outcomes measures, data collection instruments, and methods for risk adjustment. Later work will address strategies for using the measures to improve the quality of patient care and to pilot test the measures and strategies developed in both managed-care and fee-for-service environments.<sup>10</sup>

---

<sup>8</sup> In February 1997, NCQA released version 1.1 of the Quality Compass, which includes updated information and data from 41 new participants, bringing the total to 250 health plans.

<sup>9</sup> The Commission's 1995 annual report provides a description of the types of health plan performance reports being developed and an overview of their content (PPRC 1995).

<sup>10</sup> It may be difficult to use many outcomes measures in quality improvement projects, because it is not always clear which health care processes are associated with a given outcome.



## USING HEALTH PLAN PERFORMANCE AND QUALITY MEASURES

Health care purchasers and health plans have demonstrated the potential to use information on health plan performance in a variety of ways. Many innovative purchasers have moved beyond the collection and reporting of information on their contractors' performance. Some now take into account information on quality and other aspects of plan performance in making contracting decisions, for example. Others use this type of information to steer enrollees to plans that appear to offer the highest levels of quality or value. These types of uses in Medicare look promising for the future.

A number of issues must be taken into account in determining which uses are appropriate for Medicare and how various alternatives might be implemented. This section begins with a discussion of factors that must be considered in identifying appropriate and feasible uses for health plan performance data in Medicare. It then describes the ways in which health plan performance data could be used in the Medicare program. It concludes with an overview of various implementation issues.

### Factors Determining Appropriate Uses of Performance Information in Medicare

Perhaps the most fundamental questions to be addressed in deciding how to use health plan performance data in Medicare are those pertaining to political feasibility. Is there something about a public program that constrains its ability to act like a private-sector purchaser? If performance is found to vary significantly among participating plans, what actions are appropriate and which does HCFA have the ability to take? Differentiation of health plans on the basis of quality and performance would be new to the Medicare program, and HCFA's options for doing so may be constrained in some ways. For example, the agency might need legislative authority to implement certain options for using health plan performance information.

Changes in the health care marketplace may make the use of performance information in Medicare more politically feasible. It is important to remember that many purchasers are now using information on plan performance in some fashion. If HCFA is not able to do so as well, beneficiaries may soon be counted among the minority of health plan enrollees who do not have a purchaser looking out for their interests and demanding accountability for performance. Local consumer groups, the press, or advocacy groups could also play a role in the collection, dissemination, or interpretation of quality and performance information, however.

In addition to questions regarding political feasibility, any potential uses for health plan performance and quality information will need to be evaluated in light of relevant technical considerations.<sup>11</sup> Comparability is one of the most important. Health plan performance measures can be used to compare plans as well as to track changes in performance of a plan over time. Any comparisons of

---

<sup>11</sup> These considerations are above and beyond those pertaining to the selection of measures to be used. In previous reports, the Commission described an array of factors by which to evaluate quality and performance measures (PPRC 1994). For example, the Commission called for use of measures that could improve processes or outcomes of care, and those that encompass the range of medical care provided.



plans made on the basis of quality measures need to reflect legitimate differences in plans' performance. Otherwise, comparisons would be unfair and misleading. Where measurement efforts do not account for meaningful differences in the populations plans serve, comparisons could also increase plans' incentives for differentiating among enrollees or potential enrollees on the basis of health status or other factors.

The Commission has noted two important concerns that arise when using performance measures to make comparisons among plans (PPRC 1995). First, differences in the measurement methods or the types of data used to estimate measures, or in the accuracy or completeness of plans' data sets, could make comparisons unreliable. Second, risk adjustment may be required to control for differences in plans' enrollment that affect estimates of performance. Few risk adjusters for performance measures have been developed, however, and it is unclear which enrollee characteristics have the most influence on performance measurement results. The importance of making adjustments to measures is likely to depend on the extent to which plans' populations differ. Some types of measures will be more sensitive to underlying characteristics of the population.<sup>12</sup>

In light of these comparability issues, any use of performance measures to make comparisons among plans participating in Medicare should proceed carefully. Only one of the seven Medicare HEDIS measures prescribes a risk-adjustment method—although, as an outcomes measure, this is likely to be the measure most sensitive to enrollment characteristics. In addition, most of the measures feature alternative specifications for measurement.<sup>13</sup> Alternative measurement specifications will be necessary as long as considerable variation remains in plans' data systems and in the accuracy and completeness of data collected.

### **Options for Using Measures**

There is a wide spectrum of potential uses for information on health plan performance and the quality of care plans provide. Each offers benefits for the Medicare program by promoting quality, fostering competition, or protecting beneficiaries. Options are not, in most cases, mutually exclusive. Some approaches for using the information are likely to be more feasible than others, particularly in the short term. Among the most feasible are those that emphasize quality improvement or consumer information strategies, compared with options that would have this type of information affect decisions regarding program participation or payment.

---

<sup>12</sup> For example, outcomes measures (e.g., mortality rates) may be more sensitive than process measures (e.g., flu shot rates) to enrollment composition. In addition, measures of health care quality may be more sensitive than survey measures of beneficiaries' experiences and perceptions. The Commission previously observed that the degree to which adjustments to measures will affect estimates was not clear from early performance reports. For example, survey results published in the performance report prepared by the Federal Employees Health Benefits Plan were adjusted for age, sex, and health status, but comparisons with unadjusted data show significant differences in only a few cases (PPRC 1995).

<sup>13</sup> An example is the HEDIS 3.0 measure of diabetes care. Plans can use either pharmacy data, claims or encounter data, or medical record review to determine which enrollees have diabetes, the first step in calculating the percentage who have had an annual eye examination. The eye examination itself can be documented using either medical record review or claims or encounter data.

**Quality Improvement Projects.** Many of the health plan performance measures that have been designated by HCFA for use in Medicare provide information on quality of care, and thus may be appropriate for use in the Medicare quality improvement program. The Medicare HEDIS measures, in particular, would be appropriately used because they specify clinical areas for performance assessment and provide measurement specifications.

Under current contractual arrangements (often referred to as the fifth scope of work), Medicare's QIOs now work with managed-care plans to develop quality improvement goals in specific clinical areas, implement improvement projects, and measure performance at baseline and periodically thereafter. The clinical areas to be assessed and the data used for assessment are not designated by HCFA, but are determined through negotiations between the QIO and the area health plans. That represents a change from the former quality approach, under which Medicare's peer review organizations were responsible for reviewing certain percentages of medical records to evaluate quality on a case-by-case basis.

Designating HEDIS measures for use in Medicare managed-care quality improvement projects would offer advantages over the current approach. First, the clinical aspects of care for which HEDIS measures have been developed are those in which experts have agreed that measurement is both useful and feasible.<sup>14</sup> In addition, use of the measures for quality improvement activities is attractive because it does not require making administrative decisions based on comparisons among plans, postponing the need to address questions about risk adjustment and the comparability of data systems. HEDIS measures need not necessarily be the only ones used in quality improvement projects, though, as locally identified quality issues might best be addressed using other measures.

**Program Monitoring Applications.** Systemwide monitoring serves a valuable purpose in that it enables the identification of any problem areas so that program policy changes can be implemented as needed. Aggregated estimates of plans' performance could be used as a tool for monitoring the Medicare managed-care program, much as measures based on claims and survey data are currently used in monitoring fee-for-service Medicare. The Commission, for example, uses claims to monitor trends in the type and quantity of services provided and has used these data to estimate clinically based measures of access to care (PPRC 1995). It also uses survey data to assess access and satisfaction in fee-for-service Medicare. Parallel monitoring activities for Medicare managed care could utilize plan-level satisfaction, performance, and quality data.

**Consumer Information Uses.** HCFA has indicated that it intends to make information on health plans' performance available for beneficiary review. Such use would be consistent with numerous private-sector initiatives in this area, such as NCQA's Quality Compass and various efforts sponsored by states, consumer groups, individual employers, and health plans. HCFA's use of performance data

---

<sup>14</sup> Among the criteria used in selecting measures for HEDIS 3.0 were the extent to which the measure addressed aspects of care known to affect controllable health outcomes, could be produced at reasonable cost to the plan, and could be estimated using methods that would not threaten patient confidentiality (NCQA 1996).

to inform beneficiaries would raise a number of issues for implementation, however, and it also may be controversial because it promotes comparisons among plans on the basis of the performance measures.

By providing information on plan performance to beneficiaries, HCFA would be implicitly or explicitly inviting beneficiaries to make comparisons among plans based on that information. Where that was done, HCFA would also need to take steps to give beneficiaries the information needed to make comparisons wisely. For example, performance reports should describe the factors that can cause differentiation in performance measurement, such as:

- real differences in performance,
- differences in plan enrollment,
- random error,
- differences in the types of data used for measuring performance, and
- differences in the accuracy and completeness of plans' data.

HCFA should also publicize the guidelines given by NCQA regarding appropriate use of HEDIS measures to compare plans. For example, the organization recommends that measures not be considered in isolation, but rather that patterns in performance (in a specific performance domain or clinical area) should be examined. It also advises users to consider other types of information, such as accreditation status, in conjunction with performance measurement information (NCQA 1996).

HCFA is currently grappling with many issues concerning the provision of information to beneficiaries on their health plan options. These include how best to get this information into beneficiaries' hands, how to present it so that it can be understood, and how to be sure beneficiaries get the information they want and will use. The Commission has also considered these issues in chapters addressing quality of care and consumer information strategies (PPRC 1995; PPRC 1996). It has, for example, pointed out the need to standardize definitions used in materials provided to beneficiaries, and to ensure that sufficient resources are made available to support development and dissemination of informational materials. The key question yet unanswered is the extent to which the provision of performance information will influence beneficiaries' decisions or result in improved health care.

**Medicare Participation Standards.** Another option for using health plan performance measures in Medicare would be to incorporate them into HCFA's process for determining compliance with Medicare participation standards for risk and cost plans. HCFA's ability to act on performance information may be limited in certain respects, however. Under current law, HCFA has the authority to impose specific sanctions if a participating plan fails to meet legislative and regulatory requirements,



but has no authority to sanction plans based on the quality of care provided.<sup>15</sup> HCFA has also been subject to criticism for failing to use its enforcement authority to resolve problems with plans in a timely manner (GAO 1988; GAO 1991; GAO 1995).

**Preferred Plan Designation.** Yet another approach would be to use health plan performance information to determine plan eligibility for preferential status. Under this approach, plans that met or exceeded performance standards—or alternatively, plans that set the benchmarks in performance for a designated geographic area (e.g., market, state, or region)—could be designated by HCFA as preferred plans.

A range of benefits could be associated with this preferred plan status, providing plans with incentives for top performance. For example, HCFA could allow plans to advise beneficiaries of their preferred status, giving them guidance on how this status should be described in plan marketing materials.<sup>16</sup> Alternatively or in addition, HCFA could inform beneficiaries of plans so designated as part of its consumer information activities. Preferred plans might be provided with enhanced enrollment opportunities. Further, preferred plans could be offered administrative rewards for achievement, such as reduced reporting or review requirements for a specific period of time.

**Performance-Based Payment.** Another option would be to factor plan performance into the formula used to determine plan payment. The current payment rates are based on the adjusted average per capita cost to Medicare for fee-for-service beneficiaries. Payment is made without regard to services provided or outcomes of care achieved. Changes in plan payment methodology would require changes in law.

Performance-based payment would be new to the Medicare program, but not new to publicly financed health programs. For example, the Omnibus Budget Reconciliation Act of 1987 authorized states to establish programs to reward nursing facilities that provide the highest quality care to Medicaid beneficiaries. Several states responded by implementing payment systems that partially link payment to patient outcomes or other quality standards (Chapin and Silloway 1992).

Other purchasers have reported success in negotiating contracts with health plans that put them at financial risk for quality. For example, the Pacific Business Group on Health made 2 percent of

---

<sup>15</sup> Under current law, the Secretary of Health and Human Services can impose civil money penalties, suspend enrollment, or suspend payment where a plan (1) fails to provide medically necessary care, (2) imposes excessive premiums on enrollees, (3) unlawfully expels or refuses to reenroll a beneficiary, (4) engages in practices to discourage enrollment by medically needy beneficiaries, (5) misrepresents or falsifies information to the Secretary or to enrollees, (6) fails to provide prompt payment for services or offers physicians financial incentives to reduce or limit services, or (7) employs or contracts with any individual or entity excluded from the Medicare program. HCFA may terminate a contract when (1) the plan has substantially failed to carry out the terms of its contract, (2) the plan carries out the contract in a manner inconsistent with relevant law, (3) the plan has failed substantially to comply with the composition of enrollment requirements, or (4) HCFA determines that the plan no longer qualifies as an eligible organization.

<sup>16</sup> NCQA, for example, issues guidelines for ways in which accredited plans may advertise their accreditation status to purchasers and potential enrollees.

participating plans' premiums contingent upon performance in three areas: customer service, quality, and provision of data (Schauffler and Rodriguez 1996). The organization uses HEDIS measures and data collected through its employee survey to assess plans' performance.

**Selective Contracting.** A final option for using information on health plan performance in Medicare would be to use it in determining plan eligibility for Medicare program participation. Conceivably, HCFA could establish a policy of not renewing contracts with plans that failed to meet standards for quality and performance or that failed to improve their performance over time.

### **Implementation Considerations**

A variety of additional issues need to be taken into account when implementing various uses of health plan performance and quality information in Medicare. For example, HCFA will need to take steps to ensure that performance information is valid and accurate. Comparability with information on fee-for-service Medicare also requires consideration. These and other implementation issues are reviewed below, followed by a discussion of the potential for revising the 50-50 rule, a plan participation standard devised to protect beneficiaries under a Medicare program that lacked quality and health plan performance measures.

**Minimizing the Potential for Quality Trade-Offs.** One concern regarding the measurement of quality in specific clinical areas is that attention in those areas may come at the expense of attention to quality in other areas that could be equally or more important. The use of two strategies may help to minimize the potential for such trade-offs. First, measures could be rotated periodically, providing incentives for plans to keep up quality in all clinical areas. Another strategy is to use a multifaceted approach to quality assurance in the Medicare program as has been recommended by the Commission (PPRC 1996). Such an approach would rely on performance measurement as the basis for consumer-oriented reporting, quality improvement initiatives, and program monitoring. It would couple this with broader strategies including external review through accreditation or certification, and requirements for plans' internal quality assurance programs. Using this approach should provide incentives for plans to invest in their broader quality assurance programs in addition to quality improvement projects in specific clinical areas subject to measurement.

**Validity and Accuracy.** Any performance data provided by plans that HCFA uses for administrative purposes or publishes for beneficiary use will need to be audited to ensure validity and accuracy. The HEDIS report card pilot project demonstrated the importance of conducting an external audit of performance measures estimated by plans (NCQA 1995). Opportunities for significant measurement error are great, particularly as plans new to performance measurement take steps to meet Medicare reporting requirements.

**Measures for Fee for Service.** Two important issues to be addressed in any use of new information on health plan performance are how to hold providers in fee-for-service Medicare accountable in a comparable manner, and how to ensure that beneficiaries receive comparable information on all their



managed-care and fee-for-service options. One key decision will be how to group fee-for-service providers in a meaningful way—on a local, state, or regional basis, for example—for purposes of performance measurement, since most measures cannot be calculated at the level of a single provider. Efforts by the Delmarva Foundation (under contract to HCFA) to develop quality measures for fee for service and to profile providers on the quality of care they furnish could offer guidance in this area.

**Extent of Application.** One implementation strategy worthy of exploration could circumvent the political issues that may be associated with some of the more innovative uses of performance information. That strategy would involve creating opportunities for plans to participate in programs using health plan performance information, rather than mandating use. For example, plans could conceivably choose whether to participate in performance-based payment programs. Ideally, beneficiaries would have complete information on plans' participation in such programs along with other information on their options to assist them in making decisions about how they will obtain their health care.

**Enrollment Composition Rule.** One standard, originally devised to protect consumers, should be reconsidered concurrent with the enhancement of Medicare's quality assurance system through performance measurement. The so-called 50-50 rule for enrollment composition, which prohibits Medicare risk plans from exceeding a 50 percent cap on publicly insured (i.e., Medicare and Medicaid) enrollees, was instituted to increase plans' accountability and to serve as a quality proxy. The rationale was that plans that were able to attract and hold commercial enrollees would meet a market test of quality for Medicare beneficiaries. In addition, commercial enrollment would ensure that Medicare did not provide the only source of revenue for plans. At present, however, the rule presents a number of obstacles to health plans and beneficiaries. For example, the rule inhibits the development of health plans specializing in the care of elderly or disabled persons and impedes Medicare participation or market expansion of health plans. It also deters Medicare risk plans from participating in Medicaid, and thus from being able to offer comprehensive prepaid care for dually eligible beneficiaries.<sup>17</sup> In addition to presenting obstacles, the rule is arguably no longer needed now that more direct measures of health plan quality and performance are being implemented.

## REFERENCES

Chapin, Rosemary, and Glenn Silloway, "Incentive Payments to Nursing Homes Based on Quality-of-Care Outcomes," *Journal of Applied Gerontology* 11(2):131-145, June 1992.

General Accounting Office, *Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations*, GAO/HRD-88-73 (Washington, DC: August 17, 1988).

---

<sup>17</sup> See Chapter 10 for discussion of the obstacles presented by the 50-50 rule for provider-sponsored organizations and Chapter 19 for discussion of ways in which the rule affects health care options for beneficiaries who are dually eligible for Medicare and Medicaid.



- General Accounting Office, *Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards*, GAO/HRD-92-11 (Washington, DC: November 12, 1991).
- General Accounting Office, *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care*, GAO/HEHS-95-155 (Washington, DC: August 3, 1995).
- Gold, Marsha, Robert Hurley, Timothy Lake, et al., *Arrangements Between Managed Care Plans and Physicians: Results from A 1994 Survey of Managed Care Plans*, Selected External Research Series, No. 3 (Washington, DC: Physician Payment Review Commission, February 1995).
- National Committee for Quality Assurance, *HEDIS 3.0 Draft* (Washington, DC: July 1996).
- National Committee for Quality Assurance, *Report Card Pilot Project: Technical Report* (Washington, DC: February 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1994* (Washington, DC: 1994).
- Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Schauffler, Helen H., and Tracy Rodriguez, "Exercising Purchasing Power for Preventive Care," *Health Affairs* 15(1):73-85, Spring 1996.



# Issues Concerning Data Reporting by Health Plans

As Medicare expands the range of private health plan choices available to its beneficiaries, government and beneficiaries alike will have a greater need for data. Valid data are essential in choosing, managing, and improving health care delivery systems. Medicare's fee-for-service program already has in place extensive data systems that are used to monitor access to care, improve quality of care, track costs, manage the program, and conduct research. By contrast, Medicare is only beginning to develop data systems to meet its analogous responsibilities toward the risk-contracting program.

Preceding chapters discuss some of Medicare's data needs for the risk program. Diagnosis data are critical for risk adjusting payments to health plans (see Chapter 4). The Health Care Financing Administration (HCFA) is deciding whether to require risk plans to report encounter data, including diagnoses. In addition to diagnoses, information on self-reported health and functional status is needed to risk adjust payments for vulnerable populations (see Chapter 5). The Physician Payment Review Commission recommends that Medicare begin to monitor access to care in the risk program using data that permit comparisons with the fee-for-service program (see Chapter 6). HCFA is now requiring Medicare risk plans to collect and report performance measures contained in the Health Plan Employer Data and Information Set (HEDIS) (Vladeck 1997). Health plans' results on these performance measures will be made available to Medicare beneficiaries to help them choose among plans (see Chapter 7).

*This chapter includes:*

- *A recommendation that the Health Care Financing Administration define a standard core health data set for health plans to report to Medicare*
- *Capabilities of health plans to report different types of data*
- *Factors to consider when requiring data from health plans*



Medicare's needs parallel those of individuals, accrediting bodies, and other public and private purchasers. All are requesting more information from health plans on the quality, accessibility, and cost of the care they provide.

The current capabilities of health plans to collect data efficiently vary considerably, however. A few have up-to-date, comprehensive clinical information systems, while others must gather data by hand for anything beyond enrollment information. Some providers of services may be unable or unwilling to furnish information to health plans, and data from different sources may be incompatible.

Valid data can be costly to obtain, and incorrect or misinterpreted data can do more harm than good. In addition, external reporting of data by health plans requires consideration of issues such as standardization, comparability of the data across plans, and confidentiality of medical information. These factors must be considered by Medicare and other purchasers when they are deciding whether to impose reporting requirements on health plans and providers. Health plans and providers also need time to develop information systems to meet external requirements.

### *Recommendation*

*The Health Care Financing Administration (HCFA) should define a standard core health data set to meet Medicare's requirements for risk assessment and adjustment, quality improvement, access monitoring, and other performance measures. The cost of providing data should be weighed against the value of expected uses. The data set should be as consistent as possible with health plans' other internal and external data needs. Once the core data set is well defined, HCFA should require health plans and their contractors to provide the necessary data.*

This chapter is intended to inform decisions about requiring and using data from health plans. Because it is most efficient to focus external requests on the data that health plans already anticipate collecting, the chapter begins with a description of the current and potential capabilities of health plans to collect different types of data. Most plans are moving rapidly to collect encounter data, but implementation of comprehensive clinical information systems will take much longer. Health plans, Medicare, and other external data users should cooperate on the development of information systems that will meet all parties' needs.

The chapter then discusses factors that should be taken into account by those who request and use data from health plans. The uses of the information and the processes to collect it need to be considered carefully. Many uses are best served by combinations of different types of data. Effort must be devoted to making the data as accurate, complete, and comparable across plans—and in some cases, the fee-for-service program—as is required by the use. Standardization is essential; the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) assigns the federal government a key role in achieving uniform national data standards by the year 2000. Considerations of cost and confidentiality need to be taken into account.

## **THE DATA CAPABILITIES OF HEALTH PLANS**

Health plans are a natural locus for data collection and use. They comprise organized systems that are responsible for providing care to defined populations, and they have access to capital to invest in information systems. These characteristics facilitate systematic evaluation and improvement.

Health plans vary considerably in their capability to collect and report data. The situation is changing rapidly as plans and providers invest in information systems that they need to compete on quality as well as price. Health plans are collecting data for internal purposes such as utilization management, payment of providers, premium setting, and quality improvement. Many are also collecting data like HEDIS to meet emerging demands for information about performance and costs.

The burdens of external reporting of data are minimized to the extent that plans' internal information systems can generate the required data. The types of data being collected by health plans include enrollment, survey, encounter (claims), and clinical data. Each type has multiple uses, which may require different data elements and quality of data. Data collected for one purpose may not satisfy another. Plans' general abilities to collect each type of information are described next.

### **Enrollment Data**

Health plans have basic information on enrollment and disenrollment, benefits, and purchaser of care. Some plans possess information only on the subscriber and not other family members, but information on all insureds is likely to become necessary (Park Nicollet Medical Foundation 1994). Additional demographic data are not now routinely collected, but might be gathered at the time of initial enrollment in a health plan or on yearly re-enrollment. These items could include employment status, ethnicity, and family status.

### **Survey Data**

Surveys of patients can yield systematic information on their perceptions about their medical conditions and the care they have received. Surveys can provide special insight into access to care, functional status, symptoms, health knowledge, satisfaction with care, and health-related behavior such as diet. They can be done by mail, telephone, or personal interview.

Surveys are already meeting some health data needs. HEDIS requires plans to survey a sample of their enrollees to determine health status and patient satisfaction with care. Medicare administers its Current Beneficiary Survey periodically to a sample of its fee-for-service and managed-care beneficiaries. U.S. Healthcare uses patient satisfaction measures to help determine physician performance pay, a practice being adopted by Kaiser Permanente health plans and others. There are no technical barriers to the expanded use of surveys; their principal drawbacks are their cost, the potential for gaming, and bias due to nonrespondents.

## Encounter and Claims Data

Encounter and claims data document processes of care, such as the occurrence of visits, procedures, and tests, and the prescribing of medications. These data also typically include identification of the patient, provider, site of service, date of service, and diagnoses that required the service.

Fee-for-service health plans generate claims data as part of their billing and payment process. These databases include information only on processes of care that are separately billable, such as those assigned Current Procedural Terminology codes. Pharmacy services are often not included, for example. The managed-care equivalent of claims data is termed encounter data (because claims are not filed), but some processes of care in managed-care plans are not captured in these claims-like databases. Data elements do not exist for services such as telephone care, nurse triage, pharmacy and nursing outreach programs, and wellness and exercise classes, because they have not been covered by fee-for-service Medicare.

Most managed-care plans have not been collecting encounter data, but they are increasingly doing so (Park Nicollet Medical Foundation 1994). HCFA is deciding whether to require Medicare risk plans to report encounter data. The agency now requires state Medicaid programs with new Section 1115 waivers to collect encounter data in a standardized format.

All encounter data must be generated by providers before they can be transmitted to health plans. The present ability to provide encounter data differs among fee-for-service and various types of capitated providers, and between physicians and hospitals.

**Fee-for-Service Providers.** Any individual or group practice that has an appreciable fee-for-service practice—Medicare or otherwise—should be able to submit so-called dummy claims for capitated patients as well. This includes providers who send fee-for-service bills to preferred provider organizations, independent practice associations, or point-of-service plans.

The process is most efficient if the encounter record is created in electronic form by the provider. Currently, most Medicare fee-for-service providers submit claims electronically, and the same capability exists for private fee-for-service payers. Larger practices tend to have already invested in computerized billing systems because of the efficiencies they gain from those systems. Some solo practitioners and small groups, particularly in rural areas, may lack the ability to submit electronic claims because of the cost of the necessary hardware and software. It is feasible for payers to convert a limited number of paper claims into electronic form; alternatively, these physician practices could contract with an external service to submit their claims in electronic form. Although hard data are lacking, encounter data should be readily obtainable from providers with substantial experience submitting fee-for-service claims.

**Capitated Practitioners and Plans.** Since capitated providers and health plans have not needed to generate claims, they tend to lag behind the fee-for-service sector in the ability to provide encounter



data. Health plans and medical groups that subcapitate parts of care to others, such as cardiology services, may not have information about the specific encounters that occur under the subcapitation agreement. In addition, data from different providers of services may not be technically or substantively compatible.

Despite these barriers, managed-care plans increasingly require encounter data to meet the information demands of their clients (typically employers) and accrediting organizations. One management services organization based in the South, for example, reports that all of the managed-care plans it deals with require the reporting of encounter data. The PPRC/Mathematica survey of managed-care plans fielded in 1994 found that 90 percent of plans maintained encounter databases, even though provider reporting was often incomplete (Gold et al. 1995).

In that survey, managed-care plans reported that the proportion of practitioners providing encounter data varied widely across plans; on average, only two-thirds of dummy claims were being submitted. Increasingly, though, capitated providers are generating dummy claims for internal use and because managed-care plans now require them. Several multispecialty groups in California, for example, generate dummy claims for their capitated patients so that they can manage utilization and obtain information they need to negotiate capitated payment rates. Management services organizations can provide these capabilities for smaller medical groups that cannot afford to invest in information systems on their own. In Arizona, health plans participating in Medicaid managed care are required to submit encounter data. Some have helped equip larger medical groups with the capability for electronic reporting (Davis 1996).

The Medicare Choices demonstration requires participating health plans to submit encounter data via summary claims in standard Medicare fee-for-service formats (UB92 and 1500) (Ingber 1997). Because the demonstration program has been operating for only a few months, the quality of the data cannot yet be assessed.

Some capitated providers and plans have these capabilities now, but there is no complete, up-to-date information on how many do not. Many plans, however, are moving to acquire encounter data capability. It is not clear how managed-care plans and capitated provider groups can remain competitive in the future without such capabilities, but there is no ready answer to how long it will take for most or all health plans to attain them.

**Inpatient Encounter Data.** The ability to report encounter data is more advanced on the hospital side. Some states require discharge data on all patients to be reported to the state. These state discharge databases contain information on about 55 percent of all hospital stays (Dodds 1993).

Hospitals are required to report so-called no-pay bills to Medicare for Medicare managed-care patients. Kaiser Permanente hospitals that care almost exclusively for capitated patients, for example, are submitting 100 percent of their no-pay bills to the fiscal intermediaries (Brint 1996). Nationally, however, hospitals have been reporting less than half of eligible stays (GAO 1991). This is probably

because there is no benefit in doing so (i.e., they are not being paid for it), HCFA is not enforcing the requirement, and there are costs to preparing the reports. There is no inherent barrier to complete reporting, however, and the Commission recommends that HCFA enforce this requirement (see Chapter 4).<sup>1</sup>

## **Clinical Data**

The ability of health plans to collect and report clinical information in automated form lags far behind that for encounter data. Clinical data comprise signs and symptoms, diagnoses, functional status, and the results of tests and procedures. They include ultimate outcomes such as mortality, morbidity, complications, and completeness of recovery, as well as intermediate outcomes of treatment such as blood pressure or cholesterol levels.

Some of these data may be available in automated form—such as blood test, radiology, or pathology results—but most are buried in the paper medical record or are not formally collected at all. Few health plans have computerized clinical information systems. Consequently, the National Committee for Quality Assurance (NCQA) provides different options for plans to collect the clinical information needed for HEDIS performance measures. For the diabetes performance measure, for example, plans are permitted to identify enrollees with diabetes using pharmacy records, encounter data, or medical chart reviews.

For the full potential of outcomes data to be realized, though, comprehensive computerized clinical information systems need to be implemented by health plans. Collecting clinical data from medical charts can be costly, cumbersome, and intrusive to medical practices. Recognizing that automating medical records will take considerable time and resources, NCQA has prepared a guide to assist plans through a series of short- and long-term steps toward the development of full clinical information systems in the future (NCQA 1997).

The Kaiser Permanente health plans exemplify the development of clinical information systems. The systems will capture a common core set of data while permitting some additional flexibility for each region. In addition to encounter data, the information systems will contain patient histories, laboratory, pharmacy, and other clinical data. The divisions are in different stages of development, but within five years all of the new information systems are expected to be in operation (Brint 1996).

---

<sup>1</sup> If graduate medical education and disproportionate share components are removed from the average adjusted per capita cost payment base for risk plans, many hospitals would have a financial incentive to report no-pay bills to claim these payments.

## CONSIDERATIONS IN EXTERNAL REPORTING OF HEALTH PLAN DATA

Several factors need to be considered when deciding whether to collect and use health plan data. It is essential to define the uses of the data in advance. Data need to be as accurate, complete, standardized, and comparable across plans as required by particular uses. Cost and confidentiality concerns need to be addressed.

### Use of the Data

Proposed uses of health plan data need to be defined before reporting requirements are established. Particular uses have implications for the types of data collected and the processes of data collection. Each type of data has its own strengths and drawbacks. As a result, combinations of different types of data can often provide better insight than one type of data alone.

Medicare needs data to assess the quality and accessibility of care, risk adjust payments to health plans, and support diverse other activities. The types of data needed to satisfy these requirements are discussed next.

**Access to Care.** No one type of data can give a complete picture of access to care. Surveys are a mainstay of assessment of access; the Commission demonstrated the feasibility of using a survey to evaluate access to care for Medicare managed-care patients. The Commission concluded that this type of information should be collected regularly (Nelson et al. 1996; see also Chapter 6 of this report). The Commission has used Medicare claims data to examine whether fee-for-service beneficiaries received appropriate preventive care, follow-up care, and long-term monitoring of chronic conditions (PPRC 1996). Tennessee's Medicaid managed-care program (TennCare) is using encounter data to monitor the delivery of preventive and other services (Barker 1996). Clinical data can provide important insight into access by identifying outcomes that are related to poor or good access, for example, the stage at diagnosis of those cancers that can be detected early with proper screening.

**Quality of Care.** There are several dimensions to quality of care. Clinical effectiveness, patients' satisfaction with care, and the extent to which patients are informed and participate in choosing among approaches to care are all aspects of quality. Surveys are required to assess the latter patient-centered items. Judgments of clinical quality of care generally require clinical data; except for preventive services, encounter data alone are usually not sufficient (Brook et al. 1996).

The Commission has long recommended use of both outcomes and encounter data in assessing quality of care (PPRC 1994). Despite the current emphasis on development of outcomes measures, process measures will continue to be an essential component of quality assessment. Many outcomes occur too rarely in a typical managed-care population, or over too long a period of time, for statistically significant differences to be detectable among health plans (Brook et al. 1996). In these instances, there is no alternative to using measures of processes of care that have been proven to affect the



outcomes of interest. In addition, because outcomes measures are sensitive to the characteristics of the patients being studied, detailed risk adjusters need to be developed and used (Iezzoni 1994). Process measures usually only require the use of simple categorical risk adjusters.

The combination of clinical and encounter data can be quite powerful. One study, for example, used administrative databases to assess the use in the elderly of beta-blocker medication after myocardial infarction (Soumerai et al. 1997). This medication has previously been shown to reduce subsequent myocardial infarctions and mortality. A state pharmacy database was merged with Medicare enrollment and hospital claims data. The investigators found that only 21 percent of eligible elderly patients received beta-blocker medication after a myocardial infarction. Deaths and readmissions for cardiac events occurred more often in those that did not receive the medication, and the improvement in outcomes associated with use of the medication was close to what had been previously demonstrated in randomized clinical trials. The clinical outcomes measured in this study—mortality and cardiac events requiring hospitalization—were readily available from existing computerized enrollment and encounter databases.

**Risk Adjustment.** Risk adjustment, whether for payment purposes or for comparing utilization or outcomes across plans and providers, can be based on different types of data (see Chapters 4 and 5). Demographic and enrollment data alone can provide a limited degree of risk adjustment; Medicare currently adjusts its payments to capitated health plans based on these data.<sup>2</sup> The Commission has investigated the use of surveys in risk adjustment (Park Nicollet Medical Foundation 1994). Chapter 5 discusses the need to incorporate self-reported health status and functioning to risk adjust for vulnerable populations. Clinical diagnoses form the basis of risk-adjustment models such as those based on ambulatory care groups, diagnostic cost groups, and hierarchical coexisting conditions (Weiner et al. 1996; Ellis et al. 1996). These models use claims-based diagnoses to predict risk. Reporting of all encounters may not be essential for this purpose; summary diagnosis information may be sufficient, although it has some drawbacks (see Chapter 4).

**Other Uses.** Additional uses can be envisioned for health plan data. As the proportion of Medicare beneficiaries enrolled in managed-care plans increases, the representativeness of the Medicare fee-for-service databases will be progressively degraded. If comparable information is not obtained from risk plans, projects dependent on those databases will be compromised. The fee-for-service databases support activities as diverse as research on the effectiveness and quality of care, analysis of regional variation in the delivery of services, monitoring of trends in service use and health expenditures, and maintaining the accuracy of the resource-based relative value scale.

---

<sup>2</sup> Medicare factors in age, gender, reason for Medicare entitlement, Medicaid status, institutional status, and working aged.

## **Completeness and Accuracy of the Data**

It is difficult to obtain complete, accurate data. When a system of data reporting is initiated, there is a start-up period in which the data are unreliable. Providers and others need to be educated about how to code properly, and problems must be identified and solved. Even after high-quality data are obtained, continued training and quality control must be done to maintain complete and accurate reporting. Encounter data, for example, must undergo validation checks as they are received. There also needs to be a system for auditing.

Some employers and health plans are specifying in contracts the degree of accuracy and completeness of reporting required. Compliance is established by audits of medical records. Although such audits are expensive, there seems to be no complete substitute. Other forms of external validation can be used in some circumstances. Public birth records, for example, can be used to validate the completeness of encounter data on deliveries. This type of validation requires cross-linking of different databases.

Health plans themselves cannot obtain information on care that patients pay for and receive out-of-plan. This problem might be lessened as more point-of-service plans are developed. These plans receive bills for out-of-network care.

## **Incentives to Report Data**

Capitated providers are not paid based on encounter data. Reporting data consumes resources, and some providers regard these data as proprietary trade secrets. Incentives are needed to overcome these barriers, and contractual requirements may be necessary.

Incentives can be financial or nonfinancial. Financial incentives are used most often. The Tennessee Medicaid program, TennCare, for example, withholds 10 percent of each monthly capitated payment. The withhold is released when acceptable encounter data are reported for that month. If the data are more than six months late, the 10 percent withhold is permanently lost. The program has found the latter provision to be particularly effective (Barker 1996). The Arizona Medicaid program uses reinsurance as a positive incentive (Davis 1996). Plans are eligible to receive reimbursement for high-cost cases that exceed a dollar threshold in a given year, but only if they have reported encounter data on those patients in a timely fashion during the year. Because health plans cannot predict which enrollees will later become outliers eligible for reimbursement, they have an incentive to report encounter data throughout the year. In the Medicare Choices demonstration, a withhold arrangement has been written into the contracts to encourage data submission. Most of the plans will be risk adjusted, which will provide an additional incentive to provide data (Ingber 1997).<sup>3</sup> Another type of financial incentive is to pay plans for performance that needs to be established by data.

---

<sup>3</sup> Chapter 4 of this report discusses incentives for capitated health plans to report patient-level diagnosis and encounter data to Medicare for use in risk adjustment.

For providers who care for a substantial number of a health plans' enrollees, a positive nonfinancial incentive to report data is to give them useful feedback comparing them with other similar providers. One medical group association, for example, maintains an encounter database. Participating medical groups obtain comparison reports in exchange for contributing to the database (Ransohoff 1997). Feedback is less useful, however, when members of a particular health plan constitute only a small part of a provider's practice.

## **Standardization**

Standardization is essential to permit combining different providers' and health plans' reports into one database. It is indispensable for plans that contract with multiple independent providers. Standardization is also important for providers who have to report data to multiple plans.

Data must be standardized in two senses: the technical electronic format for the data, and the definitions of the data elements themselves. Uniform definitions and coding are vital but difficult to achieve in practice. Even such items as the nature of an encounter must be carefully defined.

Little standardization exists at present. There are many vendors of information systems, and groups and health plans typically customize their systems. The task of integrating disparate systems can be a costly aspect of health plan and provider mergers. Conversion to a common reporting format usually requires a software crosswalk.<sup>4</sup> An accurate crosswalk takes time and resources to develop and maintain. In addition, coding systems and practices often vary. Prenatal visits, for example, might be reported separately or could be bundled with the delivery.

Progress is being made on standardization. The National Committee on Vital and Health Statistics (NCVHS), an advisory body to the Secretary of Health and Human Services (HHS), has developed a uniform encounter data set (NCVHS 1996). Good agreement exists for the definitions of 25 of the data elements, but others will require more work before they are ready to be implemented. The latter includes such items as type of encounter and patient's stated reason for the encounter. Unique health care facility and practitioner identifiers are needed, but the National Provider Identifier and National Provider File being implemented by HCFA may meet this need.

HCFA has developed a standardized encounter data set for use by Medicare and Medicaid, called the Medicaid-Medicare Common Data Initiative (McDATA). This core set of encounter data was developed in consultation with the private sector. It is based on the fee-for-service claim forms used by physicians to bill for Part B services and hospitals to bill for Part A services (forms 1500 and UB-92). It overlaps 95 percent with the core data set developed by the NCVHS. States with new Section 1115

---

<sup>4</sup> In a pilot program of encounter data reporting in Washington, each of the eight participating plans had to crosswalk from its existing information system to a common data set (Waterbury 1996). For at least one plan, the crosswalk was done in-house and required considerable time. Some plans outsource their data processing; those plans had to contract out for the crosswalk as well.



waivers are required to provide inpatient and ambulatory care encounter data, for which a subset of the McDATA items is being used. Medicare is also using an abbreviated version of McDATA in a pilot project in Washington (Waterbury 1996). The data set was made smaller than the McDATA items to make it easier for small plans to participate.<sup>5</sup>

Medicare is also developing a new database called the Medicare Transaction System (MTS). This all-inclusive system will contain all Medicare claims data and will have the potential to incorporate encounter data from Medicare managed care in the format used in McDATA (Friedman 1996). The Medicare Transaction System is scheduled to be finalized in about four years, but the managed-care component will be among the first completed. If managed-care data are reported to HCFA and included in the MTS along with fee-for-service claims data, comparisons and combined uses of the two data sources would be facilitated.

The most significant development in the area of standardization is the passage of the Health Insurance Portability and Accountability Act of 1996. This law requires the Secretary of Health and Human Services (HHS) to adopt, with respect to various health care transactions including claims and encounters, uniform standards and definitions for data elements, and technical standards for transmission of the data. The Secretary must also establish unique identifiers for all patients and providers. The intent of the law is to promote administrative efficiency by enabling health care entities to communicate in a common language. It will make it easier to link databases and to make comparisons.

Standards promulgated by private-sector standards-setting organizations must be used or modified when possible. In adopting private-sector standards or creating new standards where no private-sector ones exist, the Secretary must rely on the recommendations of the National Committee on Vital and Health Statistics and consult with various other relevant organizations. The standards must be finalized by February 1998. This is an ambitious timetable given the size of the task, the difficult issues that must be resolved, and the number of interested parties affected by the standards.

Health plans and providers, among others, will be required to report data in the standardized format if they are requested to do so by the recipient of the data. The legislation does not require any reporting to be done, only that data be transmitted in the standardized format if requested. Recipients of data could agree to receive data in nonstandardized form, but it seems likely that entities that receive data from a number of plans will require use of the standard format. Health plans do not necessarily have to adopt the standard format for internal use; they can contract with an outside data clearinghouse to convert their internal data into standardized form. It is likely that, after the standards are established, information system vendors will build into their systems either the standards or appropriate crosswalks.

---

<sup>5</sup> The data are just beginning to be reported by the plans, so it is too early to assess their quality and completeness. The local quality improvement organization (successor to the peer review organization) will use the data to draw samples of patients to review for quality of care.

The requirement to acquire standardized reporting capability applies to each standard beginning two years after it is adopted, except that “small” health plans are permitted three years. The legislation applies to Medicare, Medicaid, the Veterans Affairs health system, the Civilian Health and Medical Program for the Uniformed Services, the Federal Employee Health Benefits Program, and all private health care plans. If the timetable is adhered to, most health plans should be able to report data in the standardized format in the year 2000.

The legislation will require use of unique patient and provider identifiers that would be common across many databases. That should make it easier to link databases containing pharmacy, laboratory, and other clinical data. Many managed-care organizations collect or plan to capture such data in their information systems. The ability to combine data from different sources is especially important for health plans in which enrollees obtain ancillary and other services from a variety of independent sources.

The ability to link health plan data easily and accurately to other databases, such as disease registries or provider databases, will permit many useful applications. With the aid of a matching algorithm, for example, a population-based cancer registry was linked to Medicare program information for 94 percent of eligible enrollees (Potosky et al. 1993). This linkage is enabling research into cost of care, risk adjustment, and disenrollment from managed-care plans by patients with cancer (Riley et al. 1995; Riley, et al. 1996).

### **Comparability**

Whenever data are used to compare health plans, the extent to which the data are comparable needs to be addressed. Noncomparability can derive from two sources: different processes may be used to collect data, and the underlying populations being compared (for example, patients or providers) might differ systematically. These possibilities need to be anticipated. Over time, the differences are likely to become better understood and any needed adjustments more precise.

The process of data collection can introduce nonrandom error (bias) into comparisons in a number of ways. Surveys can experience nonresponse bias, for example. Tests are available to detect that in some instances. In addition, this type of bias might be less worrisome when comparing capitated health plans that have similar enrollees located in the same geographic areas, because the effects of nonresponse may be similar across these plans.

Another problem can occur when the data are collected differently in different plans. One plan might determine the rate of a given procedure via a computerized encounter data system, while another might do a chart audit of a sample of beneficiaries. The two rates may not be directly comparable if the completeness and accuracy of the two modes of data collection differ.

Fee-for-service claims data can be expected to differ from capitated health plan encounter data. Such differences need to be taken into account, and at times the processes of data collection may need to be

modified. Data developed for use in one system may not capture the different processes of care that occur in the other. Fee-for-service codes do not exist for nurse telephone care, for example, which managed-care plans may sometimes use in place of office visits. In addition, the incentives for data collection differ between the two systems, which can differentially bias the data. A Commission study after the introduction of new office and hospital visit codes in 1992, for example, showed that visit codes billed by all specialties increased gradually but significantly to higher levels of codes (and therefore payment) between January 1992 and June 1994 (PPRC 1995). When managed-care organizations report encounter data on visits, by contrast, payment does not depend on the diagnosis. That is likely to produce a different pattern of visit coding than that seen in fee-for-service Medicare.

The second cause of noncomparability occurs when the underlying populations being studied differ systematically. This condition can occur because the populations are self-selected (i.e., some degree of personal choice is exercised in forming the population). If managed-care and fee-for-service patients differ systematically in their tolerance for waiting times, for example, surveys of patients may yield differing results even if the waiting times are in fact identical in the plans being compared. Two populations of patients might differ in their compliance with treatment recommendations in ways that are not amenable to change by providers. The response to treatment of Medicaid patients might be worse than that of non-Medicaid patients because of extra risk factors related to socioeconomic status. When possible, analyses need to be adjusted for such systematic differences in populations.

### **Aggregate versus Patient-Level Data**

Some purposes can be served by simple rates per enrolled population, and such summary statistics can be cheaper and easier for plans to produce. Raw data, however, would permit many more uses than summary data. Patient-level data could be combined across plans by geographic area, by disease, by procedure, or by other variables that may not be captured in summary reports. This flexibility would be especially useful in areas in which providers belong to many plans and each plan has a relatively small share of the overall market. Patient-level data are also required to develop risk-adjustment models, because the number and type of comorbidities for each patient need to be included in the model.

### **Cost**

The cost of collecting and reporting data must always be weighed against the benefits.<sup>6</sup> The development, implementation, and use of a comprehensive clinical information system, for example, can require a massive investment of resources. For the Kaiser Permanente divisions to implement their new data systems, for example, hardware must be installed at nearly every patient encounter site, processes for entering data must be developed, and extensive education and training must occur.

---

<sup>6</sup> Both the relative and absolute cost of data reporting can be important. Competitive advantages can result if particular data requirements do not apply to some types of health plans (such as fee-for-service Medicare) or are cheaper to satisfy for some types of health plans than others.



Software must be developed and linkages made to pharmacy, laboratory, and other systems. The information system must be able to handle millions of encounters per year (Brint 1996).

In addition to start-up costs, the yearly cost of running and maintaining information systems is significant. Some of the costs might be partly offset by savings. A fully computerized medical record system, for example, would spare the costs associated with filing, storing, retrieving, and transporting paper charts (Renner 1996).

It would be most efficient for external data users to utilize the information systems that plans are implementing for their own internal purposes. When additional data are needed, the minimum necessary should be required, and the data collection processes should be designed to be as efficient as possible. Employers, accrediting bodies, and government should be able to work with health plans and information systems designers to shape the future development of information systems to meet the needs of all parties. NCQA, for example, has developed a guide to the development of clinical information systems that will better meet the needs of health plan performance assessment in the future (NCQA 1997).

### **Confidentiality**

Significant issues of privacy and confidentiality are raised by the combination of unique patient identification numbers and the reporting of data outside of providers and plans (Leary 1997). Some items are particularly sensitive—such as information on mental health disorders, AIDS testing and treatment, and genetics—but maintaining confidentiality of all medical information is important to the public. The Health Insurance Portability and Accountability Act of 1996 relies on the Congress or the Secretary of HHS to develop measures to protect the security of medical data (Gostin et al. 1996). Some purposes, such as risk adjustment, might partly be met without requiring the transmission of patient identifiers to HCFA, provided that the data are audited.

Providers and health plans may have competitive or other business reasons not to want to share information about their practices with others. Health plans may want to protect certain types of information as proprietary trade secrets. Capitated provider groups may not want to report encounter data to health plans because they want to use that information to their advantage in rate-setting negotiations. NCQA's guide to developing better information systems recommends that health plans contractually require all capitated providers to report encounter data (NCQA 1997).

## REFERENCES

- Barker, Kenneth, TennCare Division of Information Services, personal communication to the Physician Payment Review Commission, November 26, 1996.
- Brint, Melissa, Medicare and Quality Resource Management, Department of Quality, Kaiser Foundation Health Plans, personal communication to the Physician Payment Review Commission, November 22, 1996.
- Brook, Robert H., Caren J. Kamberg, and Elizabeth A. McGlynn, "Health System Reform and Quality," *Journal of the American Medical Association* 276(6):475-480, August 14, 1996.
- Davis, Stephanie, Office of Managed Care, Arizona Health Care Cost Containment System, personal communication to the Physician Payment Review Commission, November 26, 1996.
- Dodds, Greg, Consolidated Consulting Group, personal communication to the Physician Payment Review Commission, January 1993.
- Ellis, Randall P., Gregory C. Pope, Lisa I. Iezzoni, et al., "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," *Health Care Financing Review* 17(3):101-128, Spring 1996.
- Friedman, Richard H., Office of Information Systems and Data Analysis, Medicaid Bureau, Health Care Financing Administration, personal communication to the Physician Payment Review Commission, November 21, 1996.
- General Accounting Office, *PRO Review Does Not Assure Quality of Care Provided by Risk HMOs*, GAO/HRD-91-48 (Washington, DC: March 1991).
- Gold, Marsha, Robert Hurley, Timothy Lake, et al., *Arrangements Between Managed Care Plans and Physicians: Results from a 1994 Survey of Managed Care Plans* (Washington, DC: Physician Payment Review Commission, 1995).
- Gostin, Lawrence O., Zita Lazzarini, Verla S. Neslund, and Michael I. Osterholm, Letter to the Editor, *Journal of the American Medical Association* 276(14):1138, October 9, 1996.
- Iezzoni, Lisa I., ed., *Risk Adjustment for Measuring Health Care Outcomes* (Ann Arbor, MI: Health Administration Press/Association for Health Services Research, 1994).
- Ingber, Melvin, Office of Research and Demonstrations, Health Care Financing Administration, personal communication to the Physician Payment Review Commission, February 28, 1997.
- Leary, Warren E., "Panel Cites Lack of Security on Medical Records," *New York Times*, March 3, 1997, p. A-1.
- National Committee for Quality Assurance, *A Road Map for Information Systems: Evolving Systems to Support Performance Measurement* (Washington, DC: National Committee for Quality Assurance, 1997).

- National Committee on Vital and Health Statistics, *Core Data Elements: Report of the National Committee on Vital and Health Statistics* (Washington, DC: U.S. Department of Health and Human Services, August 1996).
- Nelson, Lyle, Marsh Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series, No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).
- Park Nicollet Medical Foundation, *A Comparison of Alternative Approaches to Risk Measurement*, Selected External Research Series, No. 1 (Washington, DC: Physician Payment Review Commission, December 1994).
- Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, No. 96-1 (Washington, DC: May 1996).
- Potosky, Arnold L., Gerald F. Riley, James D. Lubitz, et al., "Potential for Cancer Related Health Services Research Using a Linked Medicare-Tumor Registry Database," *Medicare Care* 31(8):732-748, August 1993.
- Rama, Kathy, Office of State Health Reform Demonstrations, Health Care Financing Administration, personal communication to the Physician Payment Review Commission, November 26, 1996.
- Ransohoff, Kurt, Santa Barbara Medical Foundation Clinic, personal communication to the Physician Payment Review Commission, March 4, 1997.
- Renner, Kevin, "Electronic Medical Records in the Outpatient Setting (Part 2)," *MGM Journal* July/August 1996:60-65, 82.
- Riley, Gerald F., Arnold L. Potosky, James D. Lubitz, and Larry G. Kessler, "Medicare Payments from Diagnosis to Death for Elderly Cancer Patients by Stage at Diagnosis," *Medical Care* 33(8):828-841, August 1995.
- Riley, Gerald F., Eric J. Feuer, and James D. Lubitz, "Disenrollment of Medicare Cancer Patients from Health Maintenance Organizations," *Medical Care* 34(8):826-836, August 1996.
- Soumerai, Stephen B., Thomas J. McLaughlin, Donna Spiegelman, et al., "Adverse Outcomes of Underuse of Beta-Blockers in Elderly Survivors of Acute Myocardial Infarction," *Journal of the American Medical Association* 277(2):115-121, January 8, 1997.
- Vladeck, Bruce C., Health Care Financing Administration, Letter to the Editor, *New England Journal of Medicine* 336(6):444, February 6, 1997.
- Waterbury, Diana, Providence Health Plan, personal communication to the Physician Payment Review Commission, November 21, 1996.
- Weiner, Jonathan P., Allen Dobson, Stephanie L. Maxwell, et al., "Risk-Adjusted Medicare Capitation Rates Using Ambulatory and Inpatient Diagnoses," *Health Care Financing Review* 17(3):77-99, Spring 1996.



# Competitive Premium Contribution Models: Issues for Medicare

Both the Congress and the Administration have developed a variety of proposals that pursue the dual goals of offering Medicare beneficiaries a broader choice of health plans, while curbing the growth in Medicare spending. Some have argued that while these policy changes respond to certain issues with the current risk program, their focus on only that portion of Medicare limits their effectiveness in preserving the program in the long term and will introduce distortions into local health markets. They advocate a more fundamental change, a federal premium contribution system, which would significantly alter the way Medicare provides coverage.

Instead of paying physicians and hospitals or contracting with a limited number of health maintenance organizations (HMOs), such a system would provide a contribution that beneficiaries would use toward the purchase of health insurance from a variety of approved plans. This contribution might or might not cover the entire cost of the premium of each beneficiary's chosen plan. Because a federal premium contribution system would be a significant departure from the current program, the Physician Payment Review Commission has begun to examine the issues associated with premium contribution systems and the implications such a change would have for Medicare.

Under a premium contribution system, Medicare beneficiaries would be offered a broader choice of health plans, which would require policy decisions concerning which types of plans should be made available to beneficiaries, standards for plan participation, and mechanisms for facilitating beneficiary choice. In its 1996 annual report, the Commission addressed a number of these important policy issues. Last year's report and

*This chapter includes:*

- *A discussion of the structure of premium contribution systems and key considerations in their design*
- *An examination of two major premium contribution systems covering federal employees and California public employees*
- *The implications of integrating Medicare beneficiaries into a new system*
- *Issues in designing a federal contribution, structuring the competition among plans, and designing benefit offerings*

Chapters 2, 3, and 4 of this year's report also assess methods for determining Medicare's payment to plans and examine issues related to risk selection and risk adjustment. Moving Medicare to a premium contribution system would encompass both the risk-contracting and fee-for-service programs, raising a number of issues that go beyond those already addressed by the Commission.

This chapter first examines the theoretical or prototypical model of a premium contribution system.<sup>1</sup> It then examines the Federal Employees Health Benefits Program (FEHBP) and the California Public Employees' Retirement System (CalPERS), two commonly cited examples of premium contribution systems. It highlights the choices these programs have made with regard to structuring their premium contributions, managing the competition among plans, and designing their benefit packages to implement the theoretical model.

After examining FEHBP and CalPERS, the chapter discusses what the move to a premium contribution system for Medicare would imply. It considers four key design issues. The first involves integrating current and future Medicare beneficiaries into the new system. The other three are generic to premium contribution systems: designing the government contribution, structuring competition among health plans, and designing benefits to be offered. The pros and cons of various approaches are weighed with respect to their administrative feasibility, affect on premium price competition, ability to minimize adverse selection, and potential for controlling program costs.

## **THE PREMIUM CONTRIBUTION MODEL**

In all premium contribution systems, consumers are charged different premiums by different plans. Differences in premiums reflect three factors: how people with higher and lower health care costs are distributed among plans (risk selection), the scope of covered services (benefit generosity), and the plan's ability to control costs (plan efficiency).<sup>2</sup>

In the design of a premium contribution system, a decision must be made about who will pay for premium differences associated with each of these three factors. Many employers have been willing to have their contribution reflect premium differences associated with risk selection. They hesitate to have sicker workers charged higher premiums for the same benefits. But employers often hesitate to have their contribution reflect additional benefits or plan inefficiency. Workers who want more generous benefits or who choose inefficient plans usually pay for any differences in premiums.

---

<sup>1</sup> This model has provided the basis for proposals introduced by a variety of health economists. See Butler and Moffit, 1995; Dowd, Feldman, and Christianson, 1996; Ellwood and Enthoven, 1995; Enthoven, 1987; and Aaron and Reischauer, 1995.

<sup>2</sup> Risk selection, sometimes known as adverse selection or risk segmentation, occurs when the insured population becomes fragmented into subpopulations with significantly different average health care costs. This can result in large beneficiary premium differences that are unrelated to benefit generosity or plan efficiency. Plans with a subpopulation with higher-than-average costs are adversely selected. Plans with a subpopulation with lower-than-average costs are favorably selected.

One of the main challenges in designing a premium contribution is to distinguish among these three factors. Designers try to construct financial incentives for subscribers to act as prudent consumers and for plans to keep premiums low. At the same time, they try to reduce the impact of risk selection and encourage plans to compete on the basis of price and quality instead.

### **The Prototypical Model of a Competitive Premium Contribution System**

The prototypical model of a premium contribution system has five key characteristics:

- The sponsor, typically an employer, solicits bids from health plans to provide a specific package of benefits.
- Any health plan wishing to participate can compete for consumers during an open season period, usually held annually.
- The sponsor makes a contribution toward the cost of plan premiums. The contribution is the same no matter which plan the consumer chooses.
- The contribution typically is designed to be large enough to ensure that at least one plan in the system will be available at no cost to the consumer, but small enough to encourage consumers to select more expensive plans only if they value the plan enough to pay the full difference between the contribution and the premium.
- A core set of benefits is standardized to enhance plan comparison.

The intent of a competitive premium contribution system is to provide health coverage in a way that maximizes consumer choice and minimizes cost. Such a system is based on the assumption that consumers are more careful with their own money than they are with either their employer's or the government's. In employment-based health insurance, the employer and the employee typically share the cost of the premium. The employer usually pays about 80 percent of the premium costs (Hay/Huggins 1996). With Medicare, the government pays about 90 percent of the cost of benefits (excluding coinsurances and deductibles). When consumers are subsidized to the point where their price is only a fifth or a tenth of the cost of a product, they have fewer incentives to take cost into account when making health care choices.

Under a premium contribution system, consumers can pick among a number of different plans, with the sponsor's contribution designed to cover at least the total premium of the lowest-cost plan. As a result, consumers bear the full cost (or enjoy the full savings) associated with their choice of health plans and presumably make the most efficient choice based on their own judgment about value and price. Thus consumers should select more expensive plans only if they significantly value the enhancements those plans offer.



If adopted by the Medicare program, this approach would be expected to garner savings to the program because the competitively based approach should lead to lower premiums. The impact on beneficiaries is less clear. While some beneficiaries would also enjoy the savings from lowered premiums, others could face increased costs. That could happen if risk selection occurs, or if a beneficiary chose a plan with additional benefits or a greater choice of providers.

## **CONTRIBUTION SYSTEMS IN PRACTICE**

The Federal Employees Health Benefits Program and California Public Employees' Retirement System illustrate how the model premium contribution system has been reshaped in response to political considerations and the realities of implementation. Both have had to compromise the competing goals of fostering premium price competition, minimizing risk selection, and controlling program costs. In FEHBP and CalPERS, the premium contributions are neither the same across all plans nor are they set at the level of the least costly plan. The administrators of these systems do not rely solely on consumer choice to determine plan premiums. They do not allow all plans to compete. They sometimes limit a plan's profit per consumer, and aggressively negotiate for the health plans to offer lower prices, more benefits, or both.

### **The Federal Employees Health Benefits Program**

The Federal Employees Health Benefits Program provides health insurance to about 9 million federal workers, retirees, their dependents, and survivors, at an annual cost of approximately \$17 billion (OMB 1996). The program is administered by the Office of Personnel Management (OPM).<sup>3</sup>

FEHBP covers almost all civilian federal workers, except for some temporary employees.<sup>4</sup> Retirees are covered as long as they have been in the program for five years before retirement. Since participation is voluntary, employees may opt out of FEHBP and be covered as a dependent on their spouse's coverage, or forgo insurance entirely.

Health insurance options include traditional fee-for-service plans, preferred provider organizations (PPO), point-of-service (POS) plans, and health maintenance organizations. In 1996, 72 percent of FEHBP consumers chose fee-for-service or PPO plans. In 1997, 388 plans are offering coverage under FEHBP, with the vast majority of these plans being HMOs offered in local markets. Depending on their location, federal employees and retirees can choose between 9 and 20 plans.

---

<sup>3</sup> FEHBP was authorized by the Federal Employees Health Benefit Act of 1958 (P.L. 86-382). The program also is referred to as FEHBA, especially by congressional staff, given the name of the authorizing legislation.

<sup>4</sup> Along with federal workers, postal workers also receive their health insurance through FEHBP. Although much of the federal work force is unionized and many federal unions offer coverage under FEHBP, only the postal workers have the right to negotiate on the level of the contribution. The contributions for postal workers are based on their collective bargaining agreements and are much higher than those in the rest of the program. Given these differences, postal workers have been excluded from the following analysis.

**Structure of the Contribution.** This section describes how FEHBP determines payments to health plans. It then discusses the goals underlying the design of the contribution.

**FEHBP's Payments to Plans.** In structuring contributions to beneficiaries, FEHBP uses a hybrid formula originally designed to have the government pay an average of about 60 percent of premium costs. For most of the plans, the government contribution is set at 60 percent of the average of six plans the original designers expected to be representative of the overall system. These plans are commonly called the Big 6.<sup>5</sup> Although that contribution is generous enough to cover the entire cost of the plan premium for some inexpensive plans, the law limits it to no more than 75 percent of a plan's total premium. This leads to the government providing a different level of contribution depending on which plan the consumer chooses.

Over time, two of the six plans experienced substantial adverse selection, causing their premiums to rise faster than those in other plans. As a result the government's maximum contribution became a greater percentage of premiums for other plans. By the late 1980s, it was approaching the point where most FEHBP enrollees were in plans where the contribution was determined by the 75 percent limit. Eventually, one of the two adversely selected plans left the program, and the premium increases in the other plan stabilized. While the premiums of the remaining plan were higher than those in other plans, their growth rate was about the same or slower than the average for the other plans. With this slower growth rate, the government's share of total premium costs in 1996 dropped to 71 percent for self-only coverage and to 72 percent for family coverage.<sup>6</sup>

Linking the government contribution to the premium growth rates of particular plans made the government vulnerable to the effects of the adverse selection in those plans and resulted in the government spending more than it intended on almost every other plan in the program.<sup>7</sup>

The federal contributions and total premiums in the 19 largest FEHBP plans, encompassing about 80 percent of the FEHBP population, show substantial variation in the size of the federal contribution and the percent of the premium it covers (Figure 9-1). The federal contribution ranges from about \$1,100 to about \$1,600. It constitutes 75 percent of the least expensive plan premium, but only 47 percent of the costliest plan. In the highest-cost plans, the federal contribution is limited to 60 percent of the average of the premiums of the Big 6 plans.

---

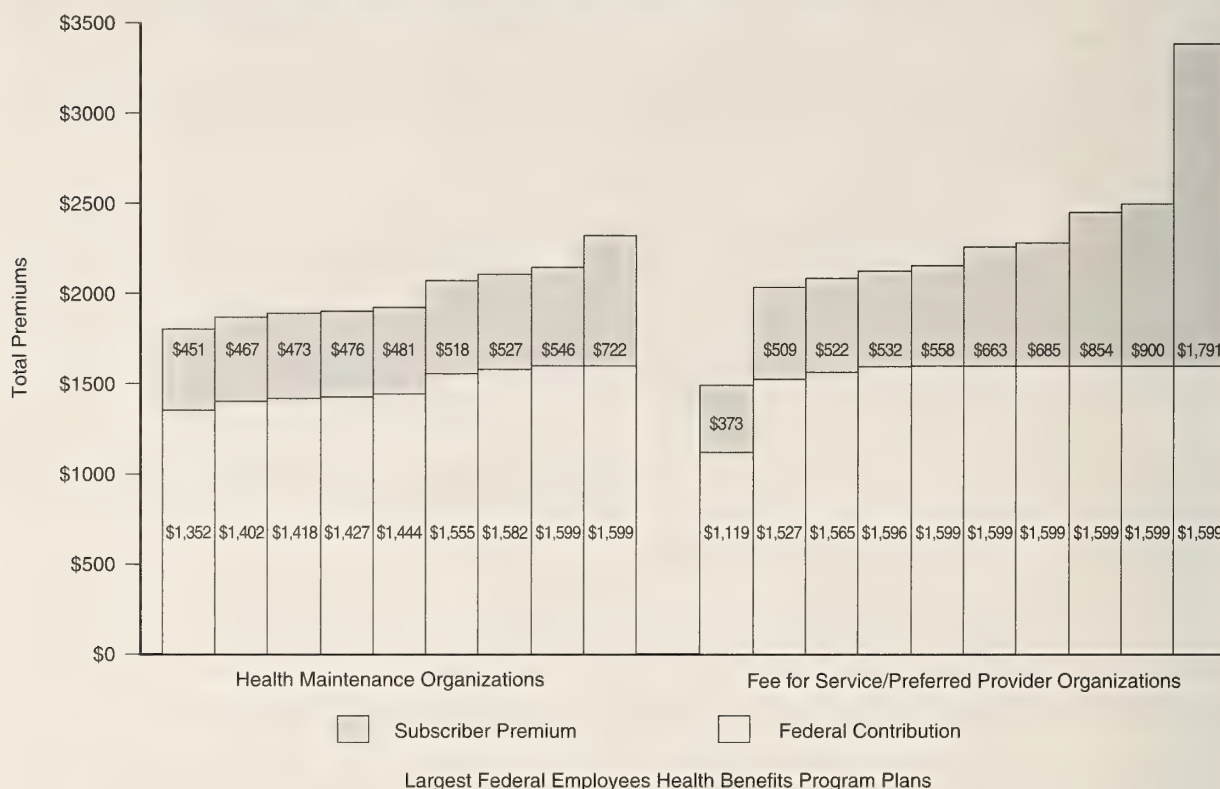
<sup>5</sup> The Big 6 were specified as (1) the high options offered by Blue Cross and Blue Shield and Aetna, (2) the two largest employee organization plans, and (3) the two largest HMOs. In the early 1990s Aetna left the program and until the Congress takes additional action, a composite of the remaining five plans known as the phantom plan serves as a place holder for Aetna.

<sup>6</sup> In examining contributions and premiums, the analysis of FEHBP and CalPERS will focus primarily on self-only coverage. This is done to assist in the comparison with Medicare, which also insures people as individuals, not as families.

<sup>7</sup> The problem of linking the government contribution to adversely selected plans was compounded because the contribution was based on the simple average of the six plans, rather than on the weighted average. This meant that even though the adversely selected plans lost a significant percentage of their consumers, their premium still counted as one-third of the average in determining the government contribution.

The interaction between the total premium and the government contribution results in a wide range of consumer premiums. Consumer premiums range from \$373 to \$1,791 for self-only coverage, but most of the FEHBP population subscribes to plans with mid-range premiums. Total premiums vary by 127 percent, government contributions vary by 43 percent, and consumers' premiums by 380 percent.<sup>8</sup>

**Figure 9-1. Annual Premium and Federal Contribution for Self-Only Coverage, Federal Employees Health Benefits Program, 1996 (dollars)**



SOURCE: Office of Actuaries, Office of Personnel Management.

NOTE: Federal contribution is the lesser of 75 percent of premium or \$1,599.

**The Goals of Contribution Design.** The structure of the FEHBP contribution encourages, but does not maximize, competitive premium prices. The maximum government contribution is set higher than in the model premium contribution system described above. But for those plans with premiums above the FEHBP maximum any difference is fully paid by the consumer. In the higher-cost plans the

<sup>8</sup> FEHBP has plans in every major market in the country. While the fee-for-service and PPO plans have a national premium, the HMO premiums reflect local markets and thus vary geographically. Some variation in HMO premiums may be due to input prices. For example, the most expensive HMO is in New York, a high cost area. But there is more to HMO premium variation than input prices. The least expensive HMO in Figure 9-1 is in Washington, D.C., suggesting that the differences in premiums reflect variations in other factors such as health status and plan efficiency.



prototypical model is followed and price competition is maximized. In addition, the financial risk to taxpayers is limited, but nothing is done to offset adverse selection.

As discussed above, linking the FEHBP contribution to the unweighted-average of six plans led the government to provide a larger contribution than it had intended. In addition, setting the contribution at a maximum of 75 percent of the premium has its limitations. First, it does not distinguish between high premiums caused by adverse selection, which the government might want to offset, and those caused by other factors such as plan inefficiency, which the government would not want to subsidize. Secondly, it weakens the incentives for price competition. Consumers who shift to a lower-cost plan keep only 25 percent of the premium savings, while those shifting to higher-cost plans pay only 25 percent of the additional premium cost.

**Structure of the Competition.** Each year, plans submit premium bids to OPM. For fee-for-service and preferred provider organization plans, OPM negotiates for the lowest premium that its actuaries consider to be actuarially sound.<sup>9</sup> For HMO and point-of-service (POS) plans, OPM requires the premium to be as low as the HMO or POS offers its other customers with subscriber populations the size of FEHBP's.

OPM negotiates with fee-for-service and PPO plans over a fixed profit per subscriber, usually between 0.50 percent and 0.75 percent of the premium. That provides an incentive for the plans to maximize market share, or at least to avoid losing market share to one of the other plans. To reduce risk selection OPM has limited the variation in benefit packages. Without risk adjusting contributions, however, plans are still better off attracting individuals with lower health care costs.

OPM has been able to obtain premiums that reflect local markets for hundreds of HMOs nationwide because it accepts the best deal local employers can negotiate. Each HMO must provide information on two of its similarly-sized subscriber groups, which typically are other large employers. Adjustments are made for significant differences in covered populations and benefits offered. The percentage profit the HMO is allowed is no more than that for the lower of the two comparison groups.

---

<sup>9</sup> In competitive premium contribution systems like FEHBP and CalPERS, where beneficiaries are allowed to shift between plans during an annual open season, there is an additional level of difficulty in accurately estimating premiums. The subpopulation at the end of the open season can have very different characteristics than the projected subpopulation upon which the premiums were based. That is especially true among smaller plans. To protect the consumers and ensure the premium is sufficient to cover costs, the administrators of FEHBP and CalPERS analyze the soundness of plans' financial reserves. Because of uncertainty about the subpopulation to be insured, financial reserves in systems with open seasons are higher than elsewhere in the insurance market. In FEHBP's case, reserves are held both by the health plan and by OPM. One result is that, at least in the first few years of a competitive premium contribution system, the premiums will be higher than normal until these additional reserves are in place.

**Structure of the Benefit Package.** FEHBP benefits are structured to achieve several objectives:

- offering consumers some choice of benefits,
- constraining benefit variation to facilitate consumer comparison of plans based on price,
- limiting certain types of benefit designs that might exacerbate adverse selection, and
- limiting benefit expansions that might add to government costs.

The core benefits are specified in law and cover basic services (e.g., inpatient hospital and physicians' services). Each year OPM specifies certain changes to benefits. For example, all FEHBP plans must cover bone marrow transplants for women with breast cancer, and no FEHBP plan can have a preexisting condition exclusion.

Plans are allowed to vary the benefit packages and to offer multiple packages. In 1989, the actuarial value (i.e., benefit generosity) of the self-only benefit packages varied by 42 percent, and the actuarial value of family benefit packages varied by 56 percent (CRS 1989).

In recent years, FEHBP administrators have aggressively limited the variation in benefit packages to facilitate consumer comparison of plans and limit some of the risk selection among plans. Plans with generous packages were allowed to eliminate some benefits, while those with minimal packages were required to enhance their benefits. The difference in actuarial value of these packages narrowed to as little as 10 percent by 1997<sup>10</sup>

FEHBP plans are in stiff competition with one another for market share. In addition, consumers from two-earner families often have the option of choosing coverage from outside insurers. That places pressure on FEHBP plans to respond to benefit expansions offered by outside insurers. To constrain spending, the program often requires benefit changes to be budget neutral. For example, if a plan wants to add dental coverage, FEHBP administrators will ask for actuarially equivalent cuts in other parts of the benefit package.

### **The California Public Employees' Retirement System**

The California Public Employees' Retirement System administers health benefits for about 1 million people. State employees, retirees, their dependents and survivors make up about two-thirds of the CalPERS population. Municipal employees and retirees, together with their dependents and survivors constitute the remaining one-third of the CalPERS population. Each year, CalPERS negotiates contracts with about 20 health insurers. For the last few years, only HMOs and PPOs have participated

---

<sup>10</sup> Based on discussions with the staff of the Office of the Actuary, OPM.

in the program, including two PPOs CalPERS is financially responsible for and operates through third party administrators.

**Structure of the Contribution.** The size of the state's contribution is determined largely by the state's negotiation with its labor unions. The state provides a flat contribution that differs according to consumer categories (i.e., active workers, retirees, Medicare beneficiaries, and families). Unlike FEHBP, it does not vary the contribution by plan. The contribution for active workers has been frozen for the last three years because of an impasse with the state employee unions. The state contribution is much more generous than the FEHBP contribution. For self-only coverage in 1996, the maximum contribution for state employees was \$2,088, while FEHBP's maximum contribution was \$1,599.

For the majority of plans, employees have no premium costs whatsoever. The state's contribution varies somewhat in the plans where there are no consumer premiums, because some of these plans set their premiums below the state's \$2,088 contribution (Figure 9-2).

**Figure 9-2. Annual Premium and State Contribution for Self-Only Coverage, California Public Employees' Retirement System, 1996 (dollars)**



SOURCE: Health Planning Administration, California Public Employees Retirement System.

NOTE: The state contribution is the lesser of the premium or \$2,098.



Plans also have an incentive to hold down premiums to attract municipal employees. Their employers' contribution is often not as generous as the state contribution, so consumer premiums greater than zero are more common.

Flat contributions can encourage price competition, requiring consumers to bear the full cost or enjoy the full savings associated with their choice of health plans. In CalPERS, however, the premiums facing consumers are more like a cliff than a continuum. Price competition involves consumers choosing between 16 plans that have no consumer premiums or one plan with a \$984 consumer premium.<sup>11</sup>

**Structure of the Competition.** The structure of the CalPERS contribution has significant ramifications for plan competition. The level of the state contribution appears to provide little or no incentive to plans to keep premiums down. A lower premium will not attract more state employees, since they already have no consumer premium. Plans have an incentive to keep premiums low to attract municipal employees who often have a lower contribution, but to further address this problem, CalPERS administrators negotiate with plans to get more competitive prices (i.e., premiums lower than the state contribution). They are able to do this aggressively, in part, because they do not have to allow all plans to participate in CalPERS.

Among the HMOs, state consumers see no differences in premium prices, but the HMOs can still compete with one another based on other factors such as quality. A very different situation occurs among the two PPOs, with premiums varying by nearly \$1,000. In effect, the size of the contribution has virtually eliminated price competition among state consumers.

CalPERS determines acceptable HMO premiums and profits in a manner similar to that used by FEHBP. It emphasizes achieving the best overall price possible. There is no set minimum or maximum profit, although plan profits are a major consideration in premium negotiations. Because CalPERS is financially responsible for its PPO plans (i.e., it is self-insured), it sets the premiums and then contracts with a number of third-party administrators to provide different benefits and services under the plans (e.g., provider networks, utilization review, and prescription drugs).

**Structure of the Benefit Package.** CalPERS has different approaches to benefit design for HMOs and PPOs. For HMOs there is a standardized benefit package. Between the two PPOs available to the general CalPERS population, there are differences in benefits, premiums and cost-sharing requirements. The PPO with the no consumer premium has the potential for significantly higher consumer out-of-pocket costs and less generous benefits than the PPO with the more expensive premium. The PPO with the higher premium also provides more benefits that might be particularly attractive to high-cost consumers, including inpatient mental health services, home health services, and skilled nursing care.

---

<sup>11</sup> A total of 21 plans participate in CalPERS, but 4 are restricted to specific groups (e.g., highway patrol, firefighters).

This benefit structure enhances the chance of adverse selection against the higher-premium PPO. In fact the 70 percent premium difference is larger than the likely costs of the additional benefits, suggesting that these extra benefits do attract a costlier group of consumers.

The vast majority of the CalPERS population is in HMOs, where there is no variation in consumer premiums or benefits. Instead plans compete with one another on such factors as quality and convenience.

## **ISSUES FOR MEDICARE**

This section discusses the issues that would have to be addressed if a Medicare premium contribution system were considered. Assessing the implications of such a system for Medicare would look to how it balanced the goals of providing access to quality health care, constraining spending to limit the financial burden on both beneficiaries and taxpayers, and minimizing risk selection.

If a Medicare premium contribution system were to be contemplated, it would require decisions on a number of questions:

- How should current and new beneficiaries be integrated into the system? Should the new system be voluntary for all current and future beneficiaries, or mandatory after a certain point in time?
- How should the government's contribution be designed? Is it possible to stimulate price competition while maintaining the current level of federal support for the program? Is it possible to create incentives for beneficiaries and health plans to control costs without exacerbating the problem of adverse selection?
- How should competition among plans be structured? How would the premium bidding process work? Should competitive behavior be promoted only through policies affecting consumers or also by allowing the program's administrators to negotiate aggressively for lower premium prices? Should the system restrict plan participation or be open to all plans? Should program administrators have the authority to remove plans with unacceptable bids from the competition?
- How should the benefit package be structured? Should there be one core set of benefits with multiple supplements or a wide variety of benefit packages? Is it possible to maximize beneficiary choice without blurring the price and quality distinctions between plans or fueling adverse selection?

Exploring different answers to these questions suggests how the Medicare program, its beneficiaries, and taxpayers might be affected by a premium contribution system. This section illustrates the

implications of various design choices, weighing their advantages and disadvantages. In most instances, component parts of the system could be combined in various ways depending on policy goals.

Two assumptions underlie the discussion that follows: First, Medicare's fee-for-service plan would remain an option within any new program. Second, there would be an open season each year during which beneficiaries would choose among plans in their market.

**The Integration of Current and Future Medicare Beneficiaries into the New System.** Integrating the current Medicare population into a new system so fundamentally different from the current program would be challenging. If current beneficiaries thought they were being coerced into an inferior system, the success of this change would be doubtful. At the same time, the current population will continue to account for the vast majority of Medicare spending for years to come, and any proposal that excluded them would greatly reduce the potential cost savings of moving to a premium contribution system in the short term.

If beneficiaries were to be integrated into a premium contribution system, a range of options could be considered. At one end, all current beneficiaries could be moved into the new system. At the other end, the current system would remain intact and the new system would be made purely voluntary.

The redesign of Social Security in the early 1980s demonstrates how the Congress has approached this issue in the past. In that case, the issue was raising from 65 to 67 the age when beneficiaries could retire with full benefits. The solution was to grandfather current beneficiaries into the old system, and phase in the new retirement age among future beneficiaries. This middle-ground approach did not require benefit cuts for current beneficiaries, but it put the future financing of the program on firmer footing. It forfeited some potential cost saving to ensure an easier transition.

The Congress could grandfather in current beneficiaries, but have all new ones enter the new program. For example, setting an age cutoff, such as at the age of 50 at the time of enactment, would give all current beneficiaries and those within 15 years of retirement the option of remaining in the traditional program.

The advantage of such a design is that it would not change the rules of the game for people close to retirement. The new program could, however, also offer options to encourage current beneficiaries to join voluntarily, such as more flexible retirement ages. Phasing in beneficiaries would give the government time to implement the new program gradually and would provide time for future beneficiaries and their employers to prepare for the new program.

A premium contribution system has the potential for offering greater flexibility in retirement age. An actuarial reduction in the contribution, similar to that used in the Social Security program, would allow



retirement at earlier ages (e.g., as early as 62 years old).<sup>12</sup> It would also allow for increasing the government contribution for beneficiaries who chose to remain in the labor force after they reached 65.

Such an approach has the potential to better coordinate with employment-based retiree coverage. For workers who retire before 65, employers would not be the sole source of coverage. For those who continue to work beyond 65, Medicare would no longer act as a secondary insurer, filling in deductibles and coinsurance, and adding to the cost of employer-provided primary insurance.

Phasing in a premium contribution system would lessen the potential cost savings associated with this approach initially. Still, making participation mandatory at some point would ensure increased cost savings. Over time beneficiaries under the age cutoff would make up a growing percentage of the program.

**The Structure of the Contribution.** The design of the contribution in a premium contribution system is critical to facilitating competitive responses by plans and consumers. Under the theoretical model the contribution is set at (or near) the cost of the least-expensive plan, maximizing consumer incentives for cost-conscious choice. It also provides protection for low-income beneficiaries by making certain at least one plan is available at no cost to the beneficiary.

In practice, it has been difficult to implement a contribution as low as the lowest premium. CalPERS found it especially hard to set a low contribution in the face of union opposition. If the premiums in the new system were to vary as much as they do in FEHBP, setting a Medicare contribution close to the lowest-cost plan would represent a significant reduction in federal payments and undoubtedly lead to higher costs for many beneficiaries.

Another consideration is that certain contribution designs can diminish the effects of risk selection. This issue would be particularly important for Medicare, since shifting the traditional fee-for-service program into a premium contribution system may cause adverse selection against it. This is because people with high costs (who presumably have a greater attachment to a particular set of providers) have more to lose by changing plans. In fact, in both FEHBP and CalPERS, the elderly and those with higher costs tend not to change plans as often. This same reluctance would be likely among the Medicare population. Moreover, for some beneficiaries who use few services, there would be little to lose and much to gain from shopping for the lowest premium. Others might be making their choices based on anticipated future use. If higher-cost beneficiaries stayed with the traditional plan, its premiums would grow at a faster rate than the rest of the program.

The experience of other premium contribution systems raises several issues related to risk selection. First, the experience from FEHBP suggests that if the traditional program were likely to experience

---

<sup>12</sup> Actuarial reductions for early retirement could be greater than under Social Security, due to Medicare's faster growth. A larger reduction in Medicare's contribution would be necessary to ensure budget neutrality. For those selecting this option, substantial employer contributions or personal savings would be required to offset this reduction.

adverse selection, linking the government contribution to it could create cost problems for the program. Removing the link, however, could limit beneficiaries' choice of plans because the contribution would cover a shrinking percentage of the premium. Second, neither FEHBP nor CalPERS is able to significantly offset the effects of adverse selection. The most promising efforts to offset adverse selection would likely come from a combination of implementing some of the newer, more effective risk-adjusters, standardized benefits, and design elements of the system (e.g., marketing rules and due process grievance procedures).<sup>13</sup>

**Deciding on a Contribution Base.** Designing a premium contribution for Medicare requires a decision about whether to administratively set the contribution or to use the plans' premium bids resulting from competition. The decision would not be simply between administratively based versus competitively based contributions, since there is a range of options between these two polar positions. The issues here are similar to those related to determining the method for capitation payments to Medicare risk plans. The principal difference is that the contribution would apply to both private health plans and the traditional Medicare program.

If designers decided on an administratively based approach, a second decision would still be required about whether to link the contribution to the traditional fee-for-service program or to all plans providing Medicare coverage. Current capitated payments to Medicare risk plans use an administratively based approach linked to fee-for-service costs. Some of the proposals considered by the last Congress would have maintained an administrative base, but severed the link to the fee-for-service costs through various means including ceilings and floors, and blending local and national rates. Chapter 3 examines the advantages and disadvantages of a number of different approaches.

There are also other possible hybrid approaches. For example, the program could use a formula similar to the adjusted community rate (ACR) methodology employed by the current program, that is still administratively based, but would examine the actual costs plans incur in providing Medicare benefits to beneficiaries.<sup>14</sup>

Adopting a competitive approach, such as FEHBP, implies that all the plans in the market would make premium bids. Plans would be at risk based on their bids, and the government contribution would be some percentage of the average bid. Competing private plans would make a premium bid for the upcoming year that reflects their best estimate of the cost of providing Medicare benefits to their covered population in a local market. An administrative accounting process could estimate the public plan's costs to generate its premium bid.

Presumably, plans would not inflate their premium bids to game the government contribution, because it would seriously compromise their competitive position in the local market (i.e., their premiums would be uncompetitively higher than the other plans). As an additional precaution, the premium bids

---

<sup>13</sup> For a further discussion of risk adjustment see Chapter 4.

<sup>14</sup> See Chapter 2 for a description of the ACR methodology.

could be broken out by estimated cost and expected profit, with both estimates subject to later audit and verification.

An administratively set contribution has the possible advantage of allowing the government greater control over what it does and does not want to pay for. Competition does not necessarily work in all local markets. In markets with limited competition among plans the government may not want to pay as much as a formula based on premium bids would indicate.

A competitively based approach has the potential advantage of being better able to respond to sudden changes in different markets. In situations where competition among plans is driving down or slowing the growth of premiums, a competitively based approach would be able to capitalize on that change by effectively self-adjusting the contribution.

Any approach that gathers data from both the traditional program and private plans (e.g., administratively based approaches that use cost reports, or competitively based approaches that use plan premium bids) has the option of basing its contribution on changes in the overall market. One approach is to use a weighted average of all plans' costs or premiums in a particular market.

If private plans have a small percentage of the market, have higher premiums, or attract few beneficiaries, then the weighted-average cost would be dominated by the traditional fee-for-service plan. As a result, beneficiaries in the traditional, government-operated fee-for-service program would see little or no change. But as more beneficiaries join plans with lower premiums, the cost of staying in less competitive, higher-premium plans rises.<sup>15</sup>

Using a weighted average approach has several advantages. It automatically tracks the movement of Medicare beneficiaries between traditional fee-for-service and private plans. The full effects of cost controls or other plan efficiencies are automatically taken into account in the contribution algorithm. A weighted average also introduces gradual change in individual markets.

There are potential disadvantages to using a weighted-average approach. One would occur if the traditional Medicare program were unable to compete effectively. The premium charged for the traditional plan would grow at a faster rate than the federal contribution. In these markets, the cost of the traditional program might become prohibitive for some lower-income beneficiaries.

This approach, like any method that could result in a reduced contribution, has the possible disadvantage of a the loss of certain benefits now offered by Medicare risk plans. Under current policy, HMOs in some markets have been able to offer additional benefits without charging beneficiaries any premium. By modifying the payment method to reflect more accurately the cost of providing the core set of Medicare benefits, the likelihood that plans could offer zero-premium options may diminish.

---

<sup>15</sup> See Chapter 3 for a further discussion of issues involving the dynamics of local markets.



In either an administratively based or competitively based approach, it is advisable to risk adjust the contribution, using a number of factors including health status (see Chapter 4). Risk adjustment is more complicated in a premium contribution system. In order to leave the beneficiary's premium unaffected by either adverse or favorable selection the contribution would need to be adjusted by a dollar amount that reflected the effect on the entire premium. For example, if a plan had an enrolled population where—given health status and other factors—the beneficiaries were expected to be 20 percent more costly than average, the total plan premium would be 20 percent higher than average as well. If the contribution were increased by 20 percent, the beneficiary's premium would still be 20 percent higher because of the effects of adverse selection. The beneficiary would still be penalized for choosing a plan with sicker people. The opposite would also be true. Beneficiaries choosing favorably selected plans would have smaller beneficiary premiums, because they were in plans with healthier people. To remove the effects of both adverse and favorable selection, the contribution would need to be adjusted by a dollar amount that reflected the effect on the total premium.

**Federal Contribution as a Percentage of the Local Base.** Selection of the contribution base is only one decision the government would have to make. It would also have to decide how much the federal contribution should cover. Many options are available and the one chosen would depend on the goals established for the new system. For example, if constraining the growth of Medicare spending were a key goal, then one decision rule would be to set the contribution no higher than it would have been under the current method of setting risk payments.

Currently, Medicare pays about 90 percent of the costs of the Medicare benefit package, not including coinsurance and deductibles. Beneficiaries' Part B premiums pay for the additional 10 percent.<sup>16</sup> Setting the contribution at 90 percent of the local base would assure beneficiaries that the federal government would maintain its proportional share of expenditures. Setting the contribution at that level would represent a trade-off between maximizing beneficiary financial protection and maximizing incentives for both cost-conscious purchasing by beneficiaries and competitive pricing of premiums by plans.

**Establishing Consumer Incentives.** There is dilemma confronting the designers of a premium contribution. If the contribution is set significantly lower than current expenditures it represents a reduction in benefits. If the contribution maintains the current federal proportion of total expenditures, the incentives either for consumers to be cost-conscious purchasers or for plans to be competitive in their premium pricing are diminished. One solution would be to allow beneficiaries who choose plans with premiums below the contribution to keep the money (or a portion of it, depending on budget considerations) that otherwise would have been spent on their premiums.

---

<sup>16</sup> In 1996 average expenditures for the Medicare benefit package were about \$5,000 for the federal government and about \$500 for the beneficiary. See Chapters 1 and 14 for information on other beneficiary out-of-pocket spending for health care.

Since a direct rebate that could be spent on non-health-related expenditures would likely be viewed as a misuse of taxpayers' dollars, an alternative would be to create a Medicare savings account similar to those offered by private employers to employees who choose lower-cost plans. The savings could be placed in an interest bearing account held by the federal Treasury. The funds could then be available to beneficiaries to pay for plan premiums, deductibles, coinsurance, or long-term care. Beneficiaries wishing to use the funds for other purposes might be allowed to do so, but with a tax penalty that would serve as a deterrent to use for non-health-related withdrawals.<sup>17</sup>

Providing a rebate or a Medicare savings account might ease the transition into a premium contribution systems for some beneficiaries. Those who might be cautious about trying one of the new private plans, if it imposes certain restrictions on choice and service use, would have some additional funds available to help finance health care expenditures outside of those covered by the plan.

In employment-based health insurance, companies do not always rebate 100 percent of the premium savings into an employee's account. A similar approach could be considered for Medicare if additional budget savings were needed. Formulas where, for example, only 80 percent or 60 percent of the savings were kept by the beneficiary might still provide substantial incentives for cost-conscious purchasing.

Under a premium contribution system, beneficiaries would choose from an array of plans with a variety of premiums. There would no longer be a uniform Part B premium, and a beneficiary's premium would vary depending on the difference between the plan's total premium and the government's contribution. For example, such a system might include a Medicare savings account with an 80 percent savings formula. If the federal contribution were \$5,000 and a beneficiary chose a plan with a \$3,000 premium, the federal contribution would be divided in three parts: \$3,000 would go to the plan to pay the premium; \$1,600 would be placed in the beneficiary's Medicare savings account; and \$400 would be returned to the Treasury (Table 9-1). Using the same example, but with a 60 percent savings formula would result in \$3,000 again being paid to the plan but, \$1,200 being placed in the beneficiary's Medicare savings account, and \$800 being returned to the Treasury (Table 9-1). Both the beneficiary and the taxpayers would have saved money under both these examples.

If a beneficiary chose a plan with a higher premium, the savings to both the beneficiary and the taxpayers would be reduced. If the beneficiary chose a plan with a \$5,000 premium, the contribution would equal the cost of the premium. In this case, no funds would be placed in a Medicare savings account, but the beneficiary would save the \$500 that would have been spent on Part B premiums. The taxpayers would save nothing in this example.

---

<sup>17</sup> Similar tax-advantaged savings plans, such as medical savings accounts and 401(k)s, carry substantial penalties for unapproved withdrawals. When medical savings accounts under Medicare were considered in the last Congress, the penalties were even higher (e.g., a 50 percent tax in addition to the individual's regular tax rate).

With a \$7,000 premium, the beneficiary would be responsible for the \$2,000 in premium costs above the government's \$5,000 contribution. The taxpayers would save nothing, and the beneficiary would pay \$1,500 more (i.e., \$2,000 under the new system compared with a \$500 Part B premium).

**Table 9-1. Comparison of Beneficiary Premiums and Federal Contributions with Different Levels of Beneficiary Savings (dollars)**

Scenario and Plan	Total Premium	Federal Contribution	Beneficiary Premium	Beneficiary Savings	Taxpayer Savings
Scenario: 80% of Savings to Beneficiary					
Plan 1	\$ 3,000	\$5,000	\$ 0	\$1,600	\$400
Plan 2	4,000	5,000	0	800	200
Plan 3	5,000	5,000	0	0	0
Plan 4	6,000	5,000	1,000	0	0
Plan 5	7,000	5,000	2,000	0	0
Scenario: 60% of Savings to Beneficiary					
Plan 1	\$ 3,000	\$5,000	\$ 0	\$1,200	\$800
Plan 2	4,000	5,000	0	600	400
Plan 3	5,000	5,000	0	0	0
Plan 4	6,000	5,000	1,000	0	0
Plan 5	7,000	5,000	2,000	0	0

**The Structure of the Competition.** The structure of the bidding process to determine plan premiums is critical to creating competition among plans. In both the FEHBP and CalPERS programs, administrators have enough autonomy and flexibility to negotiate aggressively for the best premium price. In addition, CalPERS administrators have the discretion to exclude a plan from the system if its premium bid or performance are unacceptable.<sup>18</sup> This appears to be an effective technique for obtaining lower premiums to compensate for a contribution that is too high to stimulate price competition.

In the initial years of any premium contribution system, plans may have difficulty predicting premiums because of uncertainty about key aspects of the system, such as changes in the insured population during the open season and factors used in determining the contribution. Plan uncertainty can result in higher premiums as plans incorporate larger reserves into their premium bids to protect against insolvency. The government could help offset some of this uncertainty by providing certain key pieces of information at the outset of the bidding process.

That process might be structured as follows: Each year the government would specify the core benefit package, the supplemental benefit options, and any other administrative changes for the new annual

<sup>18</sup> For most FEHBP plans, failure to reach a compromise with plan administrators leads to a hearing before a senior official of the Office of Personnel Management. If after that hearing no acceptable outcome can be agreed on, the plan can be dropped from the program. Removal of the plans specifically mentioned in the authorizing statute would require an act of Congress.



cycle. It would also give plans information on whatever risk-adjustment methodology it intends to use to adjust contributions.

In response, plans would submit premium bids for the core benefit package based on the prior year's experience and their best estimates of the population anticipated after the end of the open season.<sup>19</sup> At this point they would also submit a bid for any of the supplemental benefit packages they might offer.

One way to bring the government-run fee-for-service plan into the process would be for it also to submit the equivalent of a premium bid. The government's bid could be administratively determined and cover the expected costs of providing coverage to the population expected to remain in the traditional plan. The traditional program would charge beneficiaries a premium like any other plan in the system.

Bid submission would be followed by premium negotiation. Typically negotiations in existing systems focus on three issues: actuarial soundness of the premium bids, whether the bid is as low as the market will bear, and whether the benefit design blurs consumer choice or fosters adverse selection.

For a premium bid to be actuarially sound, government actuaries would need to be convinced that the premium was adequate to pay for the benefits being offered to the population most likely to choose that plan. Experience from existing systems reveals that allowing choice among a variety of plans results in higher financial reserve requirements than those in other parts of the insurance industry. The building of reserves might lead to higher premiums in the first few years of the program, until adequate reserve levels could be established.<sup>20</sup>

The goal of the negotiations for the program administrators would be to set the lowest premium price possible. Once convinced that the plan premium is as low as possible while still actuarially sound, the administrators would also have to review any supplements or benefit design variations to ensure they do not blur the consumers' ability to compare plans or lead to adverse selection.

Medicare currently gives beneficiaries the option of changing plans after one month. Allowing beneficiaries to switch plans during the year would become more complicated if Medicare moved to a premium-based system. Both FEHBP and CalPERS use a one-year enrollment period. A monthly

---

<sup>19</sup> If the risk adjustment methodology proved to be effective it may be better to have the plan bid based on a typical population, rather than on its own population from the previous year. Using a typical population may permit greater comparison across plans.

<sup>20</sup> The FEHBP has handled this problem by creating two levels of reserves, one at the plan level and one at the system level. At the plan level, plans typically hold reserves to cover one month's operations, giving them an 8 percent cushion if they have underestimated the cost of the covered population. FEHBP's second reserve, referred to as the contingency reserve, is held by the Office of Personnel Management and serves as a backup if a plan were to use up all of its own reserves and go out of business before the end of the year. Program administrators do not necessarily require the same level of reserves for every plan. Plans with more stable premium experience and established reserves are in a less vulnerable position. Plans that have surplus reserves are allowed to reduce their premiums in the following year to spend down some of these funds.

disenrollment policy provides protection for beneficiaries who are dissatisfied with their plan. It also facilitates risk selection. Under the current system, the cost of any adverse selection against the fee-for-service program is absorbed by the taxpayers. By contrast, under a new program the cost would result in higher beneficiary premiums.

Consideration of proposals in the last Congress to expand choices of health plans highlighted two issues that may discourage beneficiaries from enrolling in one of the private plans: annual enrollment and lack of Medigap portability.<sup>21</sup> If Medicare were to move to a premium contribution system with a Medicare savings account for health-related expenses, the opportunity to receive these funds and their availability to pay non-plan providers might ease some beneficiaries' concerns about being locked into a private plan for a year. If a new Medicare system were to retain Medigap coverage for beneficiaries in the traditional fee-for-service plan, it seems advisable to ensure the availability of some form of guaranteed issue or guaranteed renewability for that coverage to reduce beneficiaries' perceptions of the risk of trying a new plan.

**The Structure of the Benefit Package.** Two types of benefits could be offered under a Medicare premium contribution system: a core benefit package and standardized supplemental benefit packages. That combination would give beneficiaries a choice of benefits without significantly diminishing their ability to compare plans or fueling adverse selection. The core set of benefits could mirror the current system's benefit package, and all plans would make a premium bid based on this standard set of benefits. Following the practices of existing systems, the standardized supplemental packages would be the product of consultations between the program's administrators and the plans. Plans might propose certain supplements where they perceived a demand from beneficiaries. If the program's actuaries thought the supplements blurred price and quality comparisons or led to adverse selection, they could redesign or not approve them. If the plans thought a standardized supplement was poorly designed or unattractive, they would not be obligated to offer it. The supplements should be standardized in the sense that all plans wanting to offer a particular one (for instance, dental coverage) would have to offer the same set of benefits.<sup>22</sup>

Two major benefits typically found in employment-based health insurance are missing from the Medicare benefit package: outpatient prescription drugs and maximum out-of-pocket spending limits. These seem likely candidates for supplemental benefit packages.

A prescription drug supplement might provide coverage similar to current employment-based coverage, rather than the limited coverage available through Medigap policies. The exact details of this type of coverage would be worked out by the program administrators in negotiations with plans.

---

<sup>21</sup> See Chapter 3 of the Commission's *Annual Report to Congress 1996* for a discussion of annual enrollment and Chapter 15 of this report for a discussion of Medigap portability.

<sup>22</sup> It may be necessary to allow some variation in supplemental packages. Using the example of a dental supplement, it may make more sense to have a standardized fee-for-service supplement and a standardized HMO supplement that reflect cost sharing and other differences in providing care.

A supplemental policy offering maximum out-of-pocket spending limits could protect beneficiaries from catastrophic health care expenses. All expenses over a maximum dollar amount would be paid by the plan. Currently, a typical employment-based health plan sets an annual limit of \$1,250 per person (Hay/Huggins 1996). Given the higher average costs of the Medicare population, a \$1,250 limit might result in a prohibitively expensive premium. Since the average costs of the Medicare population are about 2.5 times those of the population with employment-based coverage, a maximum out-of-pocket spending limit of about \$3,000 might be affordable.

A supplemental policy covering expanded hospital days would offer beneficiaries some relief from their concerns about Medicare's limits on hospital stays. The current system's use of a 90-day spell-of-illness limit and a 60-day lifetime reserve could be expanded to the 365 days typically found in employment-based coverage. Utilization review and case management now applied to hospital stays in both the private and public sectors would likely contain costs associated with this benefit. In employment-based coverage with a 365-day benefit, stays of longer than 100 days are extremely rare (Hay/Huggins, 1996). Stays may be longer for the Medicare population, but this type of supplement may still have a relatively low price.

A vision care supplement could be designed to fill in some of the gaps in the Medicare benefit package. Coverage could include certain eye exams, glasses and contact lenses. As for dental coverage, under the Medicare core benefit package, it is limited. A supplement could be designed to cover such services as routine visits and dentures.

A low cost-sharing option would meet beneficiaries' demand for a product that reduces deductibles and coinsurance, as demonstrated by the popularity of Medigap coverage. While the direct cost of Medigap coverage is reflected in its premium, this supplemental coverage also imposes additional costs on the base plan. The cost of the base plan is increased because the supplemental coverage inhibits the cost-savings associated with the base plan's deductibles and coinsurance.<sup>23</sup>

Under the current system, the base plan is the traditional Medicare fee-for-service plan and increased costs are absorbed by the taxpayers. In a premium contribution system where plan premiums would vary but the Medicare contribution remained constant, the additional cost would be reflected in higher beneficiary premiums for the core set of benefits. Lower-income beneficiaries who could not afford supplemental insurance would be subsidizing wealthier beneficiaries with such coverage. This problem seldom occurs in the rest of the health insurance market, because it is uncommon for one insurer to allow another to pay the beneficiaries' cost sharing.

Care would have to be taken to ensure that any additional premium costs associated with reduced cost sharing were reflected in the supplemental premium and not the premium for the core set of benefits. The most straightforward way to deal with this problem would be to have a beneficiary receive both the

---

<sup>23</sup> For further information, see Chapter 15.



core benefit package and the reduced cost-sharing supplement from the same insurer.<sup>24</sup> A single insurer would be in a better position to track costs associated with core and supplemental coverage accurately. A single insurer would also have a strong incentive to avoid having the cost of the optional supplement make the premium for the core set of benefits uncompetitively high.<sup>25</sup>

Many Medigap insurers may be the most logical candidates to offer such comprehensive coverage (i.e., full replacement) under a new program.<sup>26</sup> They have a wealth of experience in serving the Medicare population and expertise in areas like marketing and claims processing that would be pivotal to the success of a new program. Many Medigap insurers are already offering comprehensive coverage in the commercial market, (e.g., Blue Cross Blue Shield and Prudential).

The special circumstances of the Medicaid population raise a number of issues, as discussed in Chapter 19. The Medicaid population currently enjoys additional benefits and reduced cost sharing and coordination between the Medicare and Medicaid programs directly affects their access to health services. Their integration, if at all, into a new system is an area that would require careful consideration if a federal premium contribution system were to be adopted.

Employers would also continue to have a significant role under a premium contribution system. They would still be under the same contractual and labor market pressures to provide retiree coverage. They could also help their retirees finance supplemental benefits, as many do under the current program. A move by Medicare to a premium contribution system is likely to affect employers' decisions about retiree coverage. As discussed in Chapter 15, some who currently provide defined benefit coverage might choose to move to a defined contribution.

## REFERENCES

Aaron, Henry, and Robert Reischauer, "The Medicare Reform Debate: What Is the Next Step?," *Health Affairs* 14(4):8-30, Winter 1995.

Butler, Stuart, and Robert Moffit, "The FEHBP As A Model For A New Medicare Program," *Health Affairs* 14(4):47-61, Winter 1995.

Committee on Ways and Means, U.S. House of Representatives, *1994 Green Book: Overview of Entitlement Programs*, Committee Print 103-27 (Washington, DC: July 15, 1994).

---

<sup>24</sup> Having different insurers provide core and supplemental coverage raises issues that have not yet been fully explored.

<sup>25</sup> If a different insurer provided the supplement, an actuarial estimate of how much the supplement increased the cost of the base plan could be used to transfer funds from the supplemental insurer to the insurer providing the core benefits. This method would be much less straightforward than having both core and supplement offered by the same insurer, but it could be managed.

<sup>26</sup> For a further discussion of full replacement insurance see the Commission's *Annual Report to Congress 1996*, Chapter 16.

- Congressional Research Service, *Health Care Reform: The Federal Employees Health Benefits Program*, No. 94-392 EPW (Washington, DC: May 5, 1994).
- Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, Committee Print 101-5 (Washington, D.C.: Committee on Post Office and Civil Service, U.S. House of Representatives, May 1989).
- Dowd, Bryan, Roger Feldman, and Jon Christianson, *Competitive Pricing for Medicare* (Washington, DC: AEI Press, 1996).
- Ellwood, Paul, and Alain Enthoven, "'Responsible Choices': The Jackson Hole Group Plan for Health Reform," *Health Affairs* 14(2):24-39, Summer 1995.
- Enthoven, Alain C., "Consumer Choice Health Plan," *New England Journal of Medicine* 298(12):650-658, March 23, 1978, and 298(13):709-720, March 30, 1978.
- Hay Group, *Hay/Huggins Benefits Report*, 1996 (Philadelphia: Hay/Huggins, 1996).
- Office of Management and Budget, Office of the President of the United States, *Budget of the United States Government*, Fiscal Year 1997 (Washington, DC: 1996).
- Rossiter, Louis, and Adamache, Killard, "A Blended Sector Rate Adjustment for the Medicare AAPCC," *Journal of Risk and Insurance* LVIII(2), June 1990.





# Provider-Sponsored Organizations

One of the important changes to the medical marketplace over the last several years has been the emergence of provider-sponsored organizations (PSOs). PSOs are local health care delivery systems created through the formal affiliation of providers. They can be physician-based, hospital-based, a combination of both, or even encompass other health service providers such as home health agencies and skilled nursing facilities (Cain 1996).

Provider-sponsored organizations may play three roles in the market. First, some contract with licensed health maintenance organizations (HMOs) and other health plans to provide services. These relationships frequently involve transferring risk from the plans to the PSOs via capitation payments. Second, some PSOs contract directly with self-funded employer plans. Finally, some organizations have opted to compete directly with existing HMOs to enroll members—a decision that in some states requires the PSO to be licensed as a risk-bearing entity.

From a policy perspective, PSOs create both opportunities and concerns. They are increasingly viewed as an option for expanding choices for Medicare beneficiaries. In 1995, both the Congress and the Administration proposed allowing PSOs to contract directly with Medicare. In 1997, several PSOs began enrolling Medicare beneficiaries as part of the Health Care Financing Administration's (HCFA's) Medicare Choices demonstration project.

A larger role for PSOs also raises questions about the vulnerability of consumers to PSO failures. Consumer protection can be accomplished in either of two ways: by

*This chapter includes:*

- *Descriptive information on various forms of PSOs*
- *Policy issues related to PSOs' participation in Medicare*
- *Current and proposed approaches to regulating PSOs*
- *Background on consumer protection measures*
- *Recommendations on application of Medicare standards to PSOs*

reducing the likelihood of plan insolvency or by protecting consumers in case an insolvency occurs. HMO laws have addressed both of these areas, but there are questions as to whether these same measures are appropriate for PSOs. Currently, a few states have formal regulatory statutes covering PSOs. Other states regulate them as HMOs, preferred provider organizations (PPOs), insurers, or under other existing statutes. Still others leave them unregulated, particularly if they do not assume risk.

The Physician Payment Review Commission first addressed PSOs in its 1995 annual report, with chapters on provider-driven integration and the application of antitrust laws to physician-sponsored networks (PPRC 1995). Last year, as part of its examination of plan standards under Medicare restructuring proposals, the Commission recommended equal treatment for all health plans contracting with Medicare (PPRC 1996).

This year, the Commission is reiterating the principle that the same core standards should apply to all private health plans participating in Medicare. All plans, for example, should be required to have adequate resources and financial reserves to ensure that beneficiaries are protected in case of insolvency or similar problems. At the same time, there should be flexibility in implementing and enforcing specific standards. It may be appropriate, for instance, to apply solvency standards differently to plans at full risk than to those with partial-risk contracts. It may also be reasonable to design solvency standards so that they are equally appropriate for plans owned by providers and those that contract with providers.

## *Recommendations*

*Provider-sponsored organizations that participate as risk contractors in the Medicare program should be required to meet the same standards as other plans. Flexibility should be used in developing and enforcing standards and rules as appropriate, given differences in plan design.*

*Plan participation in Medicare should be monitored to ensure that state or federal requirements do not impose unreasonable barriers to market entry for provider-sponsored organizations or other health plans seeking to participate in Medicare.*

Ultimately, the most difficult question is how to subject all types of plans to the same standards. One approach is to require that all plans obtain state licenses, assuming that state laws are updated to reflect legitimate differences between PSOs and other types of health plans. Another is to establish federal rules that apply to all plans and that offer consumers the same protection they now have under state law.

This chapter provides background information on PSOs and gives policymakers a framework for considering how PSOs should be treated under Medicare. The first section gives an overview of different types of PSOs with varying degrees of integration. That is followed by a section describing the regulation of PSOs, including new approaches being considered by state insurance commissioners.

Next, the chapter considers different aspects of how consumers are protected from the effects of plan failure. Financial reserve and deposit requirements, which offer basic protection against insolvency, are described in some detail. It also looks at regulatory requirements designed to guarantee that plan enrollees continue to get care—but are not financially penalized—in case of plan failure. (Antitrust considerations are covered in Appendix A.) Finally, the chapter offers a general perspective on how the Congress should approach policy decisions regarding PSOs in future Medicare legislation.

## **BACKGROUND ON PROVIDER-SPONSORED ORGANIZATIONS**

Defining a PSO is a challenging task. The term itself came into widespread use during the congressional Medicare debates of 1995. It may even have been chosen precisely because it did not have the specific meaning of other terms used to describe provider-based entities.

The term PSO has been used to encompass the full spectrum of health plans and networks that are owned, governed, operated, managed, or supervised by physicians, health facilities, and other licensed providers (Nilles and Jacobson 1996). At the lowest levels of integration, a PSO could be a loose affiliation of physicians or a joint venture between a hospital and several physician groups. More integrated PSOs typically have a legal structure that brings providers together under common medical and financial management and encourages coordination of various clinical and business functions of the organization.

A number of factors have contributed to the emergence of PSOs. Perhaps most importantly, PSOs are viewed as a means for providers to offset the bargaining power of managed-care organizations. According to a 1994 survey of hospitals involved in physician-hospital organizations (PHOs), for example, 88 percent of respondents indicated that contracting with managed-care organizations was a factor in the decision to form a PHO (Ernst & Young 1995).

In addition, with the rise of managed care, providers have lost income and autonomy in clinical decisionmaking. Some of these providers believe that a loss of clinical autonomy has adversely affected quality of care (Demkovich 1996). Provider ownership, therefore, could be a way to reassert the importance of the physician-patient relationship and enhance quality. The 1994 survey found that 63 percent of responding hospitals thought that enhancing quality was a reason to form a PHO (Ernst & Young 1995).

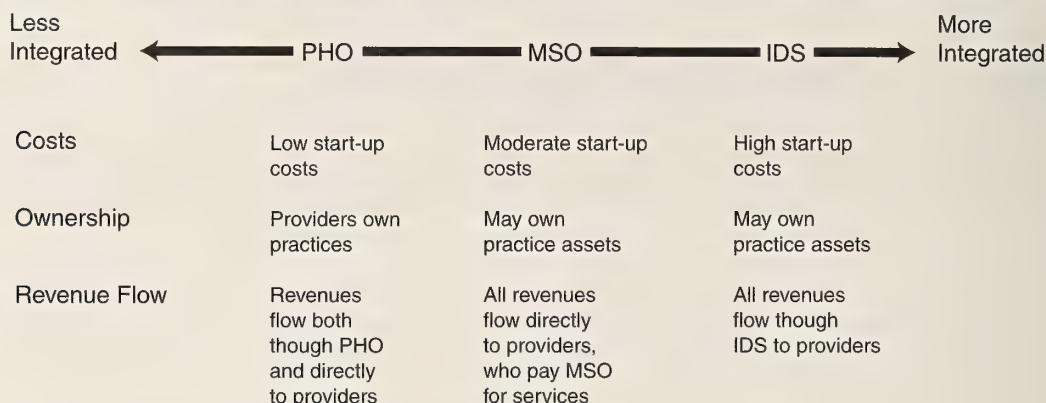
PSOs also offer several other advantages to providers. Physicians gain access to administrative expertise and capital needed to buy information services to streamline operations. In addition, hospitals consider PSOs as vehicles to ensuring steadier flows of patients (Neel 1995a).

The rest of this section briefly describes and characterizes the PSO through three of its variants—the PHO, the management services organization (MSO), and the integrated delivery system (IDS). Definitions of these structures are inherently fuzzy and may mean different things in different contexts.



The term PSO thus may be used to describe entities that exist anywhere along a continuum of integration, rather than within a handful of mutually exclusive discrete organizational structures (Figure 10-1). Background material on other types of provider organizations can be found in the Commission's 1995 annual report (PPRC 1995).

**Figure 10-1. Classifying Provider-Sponsored Organizations by Extent of Integration**



SOURCE: Physician Payment Review Commission analysis.

Ideally, PSOs could be characterized by such variables as size, age, financial status, and type of provider contracts. But without a clear-cut definition of what entities are PSOs, these data do not exist. In this section, available information on PHOs and other variants of PSOs are used as proxies to draw an approximate picture of PSOs. To the extent that any of these constitutes only a subset of PSOs, the value of these proxy data is lessened.

### Physician-Hospital Organizations

PHOs are legal entities formed by a group of physicians and one or more hospitals to further mutual interests and to achieve market objectives such as obtaining payer contracts. Under these arrangements, physicians retain ownership of their practices and agree to accept managed-care patients according to the terms of the PHO contract (Ernst & Young 1995).

**The Number of PHOs.** Because PHOs are not usually licensed, it is difficult to determine how many exist. A 1993-1994 survey funded by the Prospective Payment Assessment Commission (ProPAC) found that about 15 percent of hospitals were involved in PHOs (ProPAC 1995a). According to rough calculations, this suggests that about 800 PHOs existed during this time period.<sup>1</sup> The American Association of Physician-Hospital Organizations (AAPHO) places the number closer to 500 in 1994.

<sup>1</sup> This assumes that each hospital belongs to only one PHO. If multiple hospitals belong to the same PHO, then the true number of PHOs could be considerably lower. Conversely, if each hospital belongs to multiple PHOs (and each PHO has only one hospital), then the number of PHOs could be considerably higher.

Finally, a 1996 survey found that 28 percent of hospitals have an operational PHO, which translates to about 1,000 PHOs (Deloitte & Touche 1996).

**Characteristics.** The typical PHO appears to be both young and small. A 1994 survey found that about 74 percent of PHOs had been in existence for less than two years and 27 percent for less than six months (Ernst & Young 1995). A more recent survey found similar results, with 79 percent of PHOs less than two years old and 24 percent less than six months (AAPHO 1996). By comparison, only 1 percent of HMOs were less than two years old in 1994 (InterStudy 1995).

Although estimates vary, the average PHO apparently is smaller than the typical managed-care plan. Between 51 percent and 77 percent of PHOs had fewer than 25,000 enrollees (Ernst & Young 1995; AAPHO 1996). As a rough comparison, only 5 percent of HMOs had fewer than 25,000 enrollees in 1994 (InterStudy 1995).<sup>2</sup>

Other characteristics also suggest that PHOs are relatively small. In 1994, more than half of PHOs had operating budgets of less than \$500,000 (Ernst & Young 1995). First-year start-up cost estimates ranged from \$210,000 to upwards of \$1 million (Jaklevic 1995). Lastly, almost 89 percent of PHOs had five or fewer full-time employees (AAPHO 1996).

Finally, the typical PHO does not seem to be highly integrated. More than 50 percent had no full-time employees in finance, utilization management, information systems, marketing, or provider relations. PHOs also have limited incentives to adopt managed-care tools, because they receive capitated payments for only 18 percent of those to whom they deliver services (Ernst & Young 1995). Further, the degree of potential integration is also limited since risks are shared only for services provided through the PHO. Other aspects of the practices of participating providers are independent of the PHO relationship.

**The Future.** The future of PHOs appears uncertain. Although the numbers rose over the past few years, it is unclear if this trend will continue. In 1994, one survey found that 87 percent of hospitals either had a PHO or were developing one; by 1996 the number had fallen to 63 percent (Deloitte & Touche 1996). Therefore, even though the number of PHOs may be increasing, plans for creating more are not.

Other evidence points to a similar conclusion. Some consider PHOs to be start-up organizations for providers intending to move into more integrated delivery systems (Coile 1995). As markets continue to integrate and as capitation contracts and direct contracting with purchasers becomes more extensive, PHOs may be compelled to evolve into more integrated systems in order to remain competitive (Neel

---

<sup>2</sup> The Ernst & Young survey refers to covered lives rather than to enrollees. When a PHO is not at full risk, enrollment counts may include people who are eligible to use PHO providers (covered lives), but may not do so because they have access to other providers as well.

1995a). In fact, about half of PHOs expect to evolve into a more highly integrated structure within the next three years (AAPHO 1996).

### **Management Services Organizations**

Management services organizations are entities established by hospitals or physicians to provide services to one or more physician group practices. Some small MSOs may do little more than furnish services like billing, recordkeeping, office administration, and contract negotiation assistance. More typically, however, MSOs purchase the physical assets of physician practices and rent them back to the physicians (thus assuming management responsibility for the business aspects of the practice). These MSOs also provide capital for the purchase of such things as management information systems (Neel 1995b). This ability to transfer capital is considered one of the primary advantages of MSOs. Because MSOs are responsible for the management of entire practices, they are thought to be more integrated than physician-hospital organizations.

As with all forms of PSOs, there is scant information on how many MSOs exist and where they are located. According to the ProPAC survey, about 8 percent of hospitals were affiliated with an MSO in 1993-1994 (ProPAC 1995b). On the physician side, about 9 percent of physicians had contracts with MSOs in 1994 (Project HOPE/Gallup 1995).

### **Integrated Delivery Systems**

The term integrated delivery system refers to an entity that typically has a hospital, a large medical group, and an insurance vehicle such as an HMO or a PPO. Unlike less integrated structures such as PHOs or MSOs, in integrated delivery systems all provider revenues flow directly from the organization.

Integrated delivery systems may be organized under a foundation model, a staff model, or an equity model (Advisory Board 1993). Under the foundation model, a hospital establishes an affiliated foundation that buys the assets of a physician group and signs an exclusive professional services contract with that group. Physicians are paid for their services by the foundation, instead of directly by the payers. In the staff model, physicians work directly for the IDS without the intervening foundation and physician group. Under the equity model, physicians own a part of the IDS and share significantly in its financial success or failure.

More integrated systems are able to enjoy the advantages of both horizontal and vertical integration. One benefit of horizontal integration is that it increases access to care across geographic areas. An advantage of a vertically integrated system is its ability to move patients between different treatment settings without fear of revenue loss (Advisory Board 1993).

There is even less quantitative information on the number, size, or location of IDSs than for other types of PSOs. According to one survey, about 2.5 percent of hospitals were involved in integrated delivery



systems (ProPAC 1995b). Another survey found that 1.8 percent of medical group practices belonged to such systems in 1994 (Hoechst Marion Roussel 1995).

### **Provider-Sponsored Organizations Licensed as HMOs**

For various reasons, about one-fourth of PSOs have obtained HMO licenses from their states (Ernst & Young 1996). Although these licensed PSOs may not necessarily be representative of all PSOs, they do provide a source of comparison with organizations not owned by providers. The primary source of data was a compilation of 1993 HMO license filings for 43 states by HCIA, Inc.<sup>3</sup> These filings report on HMO assets, liabilities, enrollment, and other information required by state insurance commissioners. These data were supplemented by information on HMO ownership from InterStudy's annual HMO survey (InterStudy 1994).<sup>4</sup>

In general, provider-owned HMOs were about a year younger and slightly more than half the size of non-provider-owned plans (Table 10-1). A comparison of selected financial attributes also indicates the smaller scale of PSOs. Total assets per enrollee were about 25 percent lower for provider-owned HMOs compared with other HMOs. Notably, property and equipment accounts for almost 30 percent of the total assets of provider-owned HMOs, but for only 5 percent of total assets of non-provider-owned plans (Figure 10-2).

In addition, provider-owned HMOs receive less total revenue per enrollee, perhaps because they are more likely to serve as subcontractors (Table 10-1). Such plans may be offering a reduced set of benefits compared with larger, non-provider-owned plans. The overall distribution of revenues by source is comparable across plan ownership status, although there are differences for some sources.

Overall, data on both PHOs (described earlier) and provider-owned HMOs indicate that PSOs are younger and smaller and hold fewer resources than HMOs. Differences are far less between the two types of HMOs, probably because PSOs with HMO licenses are more mature, integrated entities than typical start-up PHOs. Although the smaller size of PSOs may be an indicator of their relative immaturity, it may also reflect their origins as locally based organizations.

---

<sup>3</sup> In accordance with the data purchase agreement, the Commission must make the following disclosure: "Data for use in this study were supplied by HCIA, Inc., Baltimore, MD. Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and HCIA, Inc., disclaims responsibility for any such analysis, interpretation, or conclusion." Data for Alaska, Hawaii, Idaho, Mississippi, South Dakota, Vermont, and Wyoming are not included because either there were no licensed HMOs in the state during 1993 or the state refused to publicly release the data.

<sup>4</sup> In some cases, InterStudy reports only the name of an HMO's owners. Where it was not clear if an HMO was truly provider-owned, it was classified as non-provider-owned.

**Table 10-1. Comparison of Selected Characteristics for Provider and Non-Provider-Owned Licensed HMOs, 1993**

Characteristic	Provider-Owned	Non-Provider-Owned
General		
Average age (in years) *	8.0	9.1
Percent federally qualified	37.4%	49.4%
Percent with Medicare risk enrollees	11.0	15.6
Average enrollment		
Medicare risk (for plans reporting risk enrollees)	7,116	37,376
Total plan	61,855	114,913
Financial (dollars per enrollee)		
Total assets	\$ 827	\$ 1,107
Percent share from:		
Cash, cash equivalents, and other current assets	55.8%	47.9%
Property and equipment	29.3	4.7
Other	14.9	47.4
Total liabilities	\$ 349	\$ 536
Total net worth	\$ 478	\$ 571
Total Revenues	\$1,397	\$ 2,923
Percent share from:		
Premium	90.1%	84.6%
Fee for service	0.3	1.8
Medicare	4.1	7.4
Medicaid	2.9	3.1
Interest	1.2	1.3
Other	1.4	1.8

SOURCE: Physician Payment Review Commission analysis of InterStudy and HCIA data for 1993.

\* As of January 1, 1994.

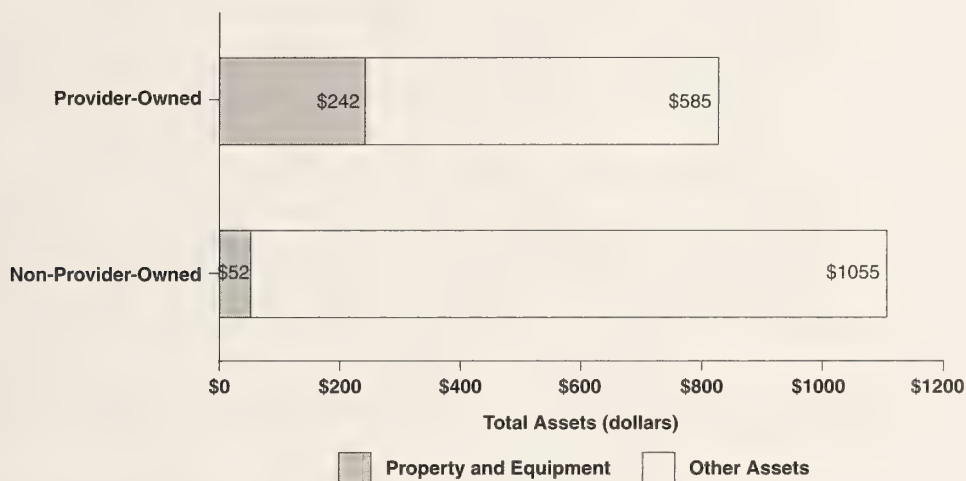
## CURRENT REGULATORY STRUCTURE

By tradition and by law, regulation of health insurers has been a state function. As HMOs began to gain popularity in the early 1970s, both federal and state governments set regulatory and oversight standards. The National Association of Insurance Commissioners (NAIC) adopted its Health Maintenance Organization Model Act in 1972 as a basis for state laws, and the Congress passed the Health Maintenance Organization Act in 1973 (P.L. 93-222).

When the Congress in 1982 established a role for HMOs as Medicare risk contractors, it specified different ways to set plan standards. Plans could either meet the standards of federal qualification as

established in the HMO Act or a similar set of standards in the Social Security Act. In either case, state licensure was necessary.

**Figure 10-2. Comparison of per Enrollee Financial Assets for Provider and Non-Provider-Owned Licensed HMOs, 1993**



SOURCE: Physician Payment Review Commission analysis of InterStudy and HCIA data for 1993.

States have responded to the emergence of PSOs in various ways. As when HMOs began to emerge in the early 1970s, PSOs have evolved largely outside the scope of existing state regulatory frameworks. Concerns about PSOs accepting financial risk have prompted state legislators and regulators to explore ways in which the regulatory structure should be modified to oversee these entities. While many states continue to deliberate, some states have developed PSO-specific laws or regulations, and others have applied existing indemnity insurance or HMO laws to PSOs.

To provide context for the evolution of PSO regulation, this section begins with a brief review of state HMO and PPO regulations and Medicare's HMO contracting requirements. A description of the ways in which states currently regulate PSOs follows. The next section offers a more detailed analysis of key approaches to consumer protection.

### State Regulation of Health Maintenance Organizations

In enacting legislation, state and federal regulators had to decide whether to impose on HMOs the same standards that existed for traditional insurers. The ability of HMOs to contain their own costs, often by passing on risk to providers, caused regulators to be less concerned about the financial solvency of HMOs compared with that of traditional insurers.



Initial federal and state regulation was designed primarily to encourage the growth of the HMO industry. The federal HMO Act, for example, included special incentives to form HMOs, such as grants, contracts, loans, and loan guarantees; liberal qualification requirements; and exemption of HMOs from existing state laws that apply to indemnity insurers.

At the same time, state governments developed new laws to regulate HMOs assuming financial risk, in order to protect consumers against insolvency and unfair marketing. All states regulate HMOs, with 29 states adopting laws based on NAIC's HMO model act. In addition, because HMOs have a service delivery function that traditional insurers lack, policymakers generally established standards for the quality of service delivery and the structure of delivery networks—functions not regulated for insurers.

State HMO regulations typically include provisions related to reserve, capital, and deposit requirements. They usually also require that HMOs maintain a quality assurance program and appeals and grievance procedures that are approved by the appropriate state agency.<sup>5</sup> In addition, HMO laws provide consumers with protection against plan insolvency, some by including hold-harmless clauses or requirements that HMOs continue some enrollee coverage in the event of insolvency (e.g., until the next open enrollment period).<sup>6</sup> Other consumer protection requirements address minimum levels of health services and benefits, information to be provided to enrollees, and prohibitions against misleading and abusive marketing tactics.

Over time, the rising popularity of HMOs was accompanied by worries about some well-publicized failures and fears that an overreaction to these failures would stifle HMO development. The 1980s proved to be a time of tremendous HMO growth. Between 1984 and 1987, their numbers almost quadrupled and plan membership more than doubled (Ahern 1991). But financial instability accompanied this growth, and the industry suffered net financial losses in 1987 and 1988. Studies of the financial difficulties experienced by HMOs during this period concluded that lack of capital and managerial expertise contributed to HMO failures.

Although financial instability and insolvency may be natural results of rapid industry growth, policymakers believed that at least some failures could have been prevented with more stringent regulations. Accordingly, amendments were added to the federal HMO Act to strengthen solvency standards that federally qualified HMOs must meet and to eliminate grants and loans to HMOs. Some states modified their HMO regulations by becoming more heavily involved in areas of fiscal solvency, consumer protection, quality assurance, utilization management, and the structure of delivery networks.

---

<sup>5</sup> Responsibility for HMO oversight is typically divided between the state insurance department and the health department.

<sup>6</sup> A hold-harmless clause protects enrollees in the event that an HMO becomes insolvent or otherwise fails to pay contracting providers by providing that enrollees will not be liable for the cost of services that should be covered by the HMO.

## **State Regulation of Preferred Provider Organizations**

Health care organizations that do not bear financial risk (e.g., preferred provider organizations) typically form networks of providers and pay them on a fee-for-service basis. Although they may raise fewer consumer protection concerns than HMOs, such plans draw the attention of regulators because they limit the network of providers that enrollees can use.

About 27 states have enacted PPO laws, generally based on NAIC's Preferred Provider Arrangements Model Act. This model law is considerably less comprehensive than NAIC's HMO model act. It contains requirements relating to disclosure, access, and provider contracts to ensure that PPO members are informed of differences in benefit levels and that providers are not unfairly discriminated against. It allows PPOs to establish terms of payment for the providers with which they contract and to include mechanisms to contain costs. In contrast to the HMO model act, it is not intended to regulate risk-bearing entities and thus includes no requirements in areas such as solvency, quality assurance, or grievances (Musser 1996). Typically, before a PPO assumes risk, it seeks an HMO license (unless, for example, it subcontracts with a licensed HMO).

## **Medicare Contracting Requirements for HMOs**

As noted earlier, Medicare requires all risk plans to be licensed by the state. In addition, the program establishes its own requirements through the Social Security Act. Medicare law requires that plans assume full financial risk for services they have agreed to cover and demonstrate that they can furnish all services available under fee-for-service Medicare in their area. In addition, plans must show they have sufficient operating experience, adequate protection against insolvency, and a quality assurance program.

Because of the state licensure requirements, many of Medicare's rules are less specific than those imposed by the states. On the other hand, where federal requirements are stricter (e.g., beneficiary appeals mechanisms), they apply.

HCFA monitors compliance through reviews of plans' documents and annual site visits. When applying for a Medicare risk contract, plans must document their qualifications. In addition, they are required to report annually on their financial solvency. Throughout the year, plans submit updates on enrollment and disenrollment. Site visit reviews include inspection of data on a plan's enrollment (including denials), disenrollment, financial performance, quality assurance, provider contracts, and grievance and appeals processes.

## **State Regulation of Provider-Sponsored Organizations**

Most states are just beginning to examine the regulatory issues related to the emergence of PSOs. State regulators generally want all risk-bearing entities to be licensed and thus be subject to certain consumer protection requirements.

A 1995 survey of state regulators by the Group Health Association of America found that most states required provider-sponsored organizations to get HMO licenses if they accept full risk (GHAA 1995).<sup>7</sup> If they assumed no risk, most states agreed that no licensing was necessary.

But the picture was mixed if the arrangements involved partial risk or downstream risk. An organization is at partial risk if it shares risk with the employer, for example, by withholding a portion of payment until total costs are reviewed at the end of the year. In a downstream risk arrangement, it accepts risk (capitation payments) from a licensed organization like an HMO. For each of these circumstances, about half the states had no clear policy. Those that did generally required licensure for partial-risk situations, even though the purchaser retained some of the risk. In the case of downstream risk, most regulators that had a policy did not require a license, since another entity (i.e., the HMO) already was licensed.<sup>8</sup> NAIC (1995) attempted to clarify the latter situations in a bulletin to all state commissioners. It stated that if PSOs (under a variety of names) accepted risk on a prepaid basis, they should be licensed in some manner. The bulletin specified an exception where the entity accepts downstream risk from a duly licensed health carrier such as an HMO.

Generally, states have taken one of three approaches when deciding whether and how to license PSOs (Figure 10-3). Many states find that existing laws and regulations may be applied to these entities — thus eliminating the need for PSO-specific regulation. A few states have established specific regulations for overseeing PSOs. Still others have done nothing or have no plans to regulate (NAIC 1996).

### **Figure 10-3. State Approaches to Regulating Provider-Sponsored Organizations**

#### License PSOs Under Existing Laws as:

- ◆ Health maintenance organizations
- ◆ Limited health maintenance organizations
- ◆ Indemnity health insurers
- ◆ Health service corporations
- ◆ Preferred provider organizations
- ◆ Health care service contractors

#### License PSOs in a New Regulatory Framework under:

- ◆ A separate licensing category
- ◆ A category that covers all risk-bearing entities

#### Require No License for PSOs

SOURCE: Physician Payment Review Commission analysis.

---

<sup>7</sup> The survey asked specifically about physician-hospital organizations. Most likely, regulators would have responded similarly to a question about PSOs in general.

<sup>8</sup> The situation is more complicated when considering the effect of the Employee Retirement Income Security Act, or ERISA, which exempts health coverage provided by self-insured employers from state regulation. As a rule, state regulators would prefer to regulate any entities with which these employers enter into risk contracts. According to a 1994 survey, half the states required that risk-bearing activity could be undertaken only by licensed entities such as insurers and HMOs—even when a PSO contracts with a self-insured employer. Most of the remaining states reported making decisions on a case-by-case basis (Ernst & Young 1994).



**Applying Existing Regulations to PSOs.** States that have not developed PSO-specific regulations have applied a variety of existing insurance and HMO regulations to PSOs. Some expect PSOs to be licensed under their HMO statutes, contending that the HMO definition is broad enough to encompass all risk-bearing entities providing health services. For example, before passing new legislation, New York had licensed 34 PSOs as HMOs. Other states that have used their HMO statutes to regulate PSOs include Arkansas, Rhode Island, and South Dakota (NAIC 1996).

A variation on this approach is to issue a limited HMO license to a PSO that assumes risk but that does not perform the other functions of a traditional HMO. California issues limited licenses to PSOs engaged in downstream risk agreements with HMOs. A limited HMO license waives requirements that do not apply to the activities of the PSO. Rules regarding marketing and enrollment would be waived, for instance, as these functions are not the responsibility of downstream risk contractors.

Other states have licensed PSOs under different laws depending on the PSO's characteristics and the definition in the state's statutes (NAIC 1996). For example, Michigan licenses some PSOs under its alternative financing and delivery system statute, which was established for managed-care plans that offer limited services and whose providers are only partially at risk for the costs of services. These plans are regulated in the same manner as HMOs, except when regulators agree that such rules are inappropriate. Michigan has 40 PSOs licensed as HMOs and 22 under its alternative statute. Similarly, Delaware uses its health service corporation law to license some PSOs.<sup>9</sup> Maine has licensed its only PSO under the state's preferred provider organization statute. Several states, among them Connecticut, Hawaii, Kansas, Utah, and Wisconsin, use indemnity insurer laws to regulate some PSOs (NAIC 1996).

Still other states have not yet licensed PSOs under any type of statute or have none to regulate. A few have indicated they are unlikely to regulate any PSOs that enter into risk arrangements with employers (NAIC 1996).

**PSO-Specific Regulation.** A 1996 study found that eight states had in place some type of laws or regulations specifically addressing PSOs (NAIC 1996).<sup>10</sup> In several other states, insurance commissioners have issued written guidelines aimed at clarifying the legal status of PSOs.

---

<sup>9</sup> As defined in Delaware law, a health service corporation is a nonprofit entity, without capital stock, responsible for operating plans to provide health care services to its subscribers.

<sup>10</sup> Counting these laws is an imprecise science, since each one is different. The American Hospital Association found that 16 states had PSO laws or regulations, though its count includes some laws that were pending and others that seem inaccurately characterized as PSO-specific laws or regulations (AHA 1996).

Those states that have enacted laws to regulate provider-sponsored organizations have generally used two approaches. One is to create a new licensure status with separate standards for PSOs. The other is to devise a new system that will apply to all entities—including HMOs, PSOs, and any others that assume risk.

Iowa was the first to enact a statute specifically related to provider networks. This legislation enables licensure of organized delivery systems (ODSs) through the state department of health. These systems are risk-bearing entities that are neither HMOs nor insurers. To become an ODS, interested organizations that wish to bear risk must file with the state, meeting certain standards and solvency requirements that appear less restrictive than current HMO requirements. Thus, a provider-hospital organization accepting capitation risk would be an ODS and would not need to become licensed as an insurer or an HMO. Since the statute's enactment in 1993, only one organization has become licensed as an ODS.

Several other states (e.g., Georgia and Kentucky) have since passed legislation to create a separate regulatory category for PSOs. The financial requirements imposed on PSOs are somewhat lower than those for HMOs.

Only Minnesota has adopted the second approach thus far, through legislation requiring all health plans to be licensed as integrated service networks (ISNs).<sup>11</sup> These entities are HMOs or other integrated delivery systems with more than 50,000 members, and include plans contracting with self-insured employers. This new license category is based largely on current HMO requirements. The regulations require ISNs to offer a standard benefits package and to include essential community providers. All existing health insurance regulations will remain effective until July 1997, when the licensing of integrated service networks is expected to be fully implemented. Thus, as of mid-1996, no plans had received such licenses.

Minnesota has also created another category of plans, called community integrated service networks (CISNs), to encourage local involvement in the development of integrated service networks. CISNs provide prepaid health services to 50,000 or fewer enrollees. Compared with ISNs, they have less stringent standards for net worth, insolvency protection, and provider risk sharing. CISNs also have a three-year phase-in period to meet net worth requirements. In addition, they are not subject to other HMO regulations with respect to quality assurance, disclosure, marketing, and reporting (Ernst & Young 1994). To give smaller entities a head start, CISNs were allowed to begin forming in January 1995. As of mid-1996, Minnesota had licensed four plans under this category.

Finally, several other states have sought to clarify current law, some in response to NAIC's bulletin on downstream risk (NAIC 1995). Illinois, Indiana, and Pennsylvania, for instance, used legislation or written guidelines from the insurance commissioner to clarify that PSOs assuming downstream risk

---

<sup>11</sup> The Ohio legislature is considering a proposal developed by the state insurance department that would license all risk-bearing entities as health insuring corporations.

from HMOs were not required to obtain HMO licenses or to meet reserve and net worth requirements normally imposed on HMOs. In writing new rules, these states did not designate a separate regulatory status for PSOs. Some are exploring ways to place explicit responsibility on the licensed entity for monitoring the solvency of subcontracting (downstream) provider organizations that assume some of the licensed entity's risk (NAIC 1996).

### **A Recent Initiative by the National Association of Insurance Commissioners**

At the same time that individual states are considering how to regulate PSOs, state insurance commissioners are collectively working both to encourage the growth of new forms of managed care and to guarantee protection for consumers who enroll in entities that may not fit clearly under existing laws. NAIC is seeking to define an appropriate regulatory status for PSOs with the expectation of writing new model laws. One part of this effort, the development of risk-based capital requirements, is discussed in the next section.

The NAIC initiative that seeks to clarify the status of PSOs and other risk-bearing entities is known as the consolidated licensure for entities assuming risk (CLEAR). It would consolidate all NAIC model statutes for licensure of various health coverage products into one new model, potentially replacing existing model statutes for HMOs and PPOs. NAIC's idea is to ensure that entities performing the same or similar functions are subject to the same rules.

The building blocks for the CLEAR initiative include a set of seven standards that are being used to amend existing model statutes in consistent ways. These standards are credentialing, quality assessment and improvement, utilization review, grievance procedures, provider network adequacy and contracting, consumer disclosure, and data reporting. Action on the first five standards was completed in 1996. Progress on the last two standards—consumer disclosure and data reporting—has been slower; decisions are expected in 1997.

There will likely be considerable debate among insurance commissioners and other interested parties on the CLEAR initiative, including the question of jurisdiction over PSOs that contract with self-insured firms. Provider groups, especially the American Hospital Association (AHA), remain concerned that NAIC's new model law will be inflexible. NAIC expects action on the overall CLEAR initiative sometime in 1998.

### **CONSUMER PROTECTION**

A central concern of policymakers has been the need to protect consumers from the consequences of plan insolvency. Because PSOs are new, it is difficult to evaluate the adequacy of current plan standards. There is, however, some historical precedent in HMO regulation that may help guide discussions of PSO consumer protection requirements. The previous section described the evolution of



HMO regulation. The HMO experience with regard to consumer protection may help policymakers decide how to protect PSO enrollees.

This section addresses two different approaches to consumer protection. First, it considers policies that might reduce the likelihood that a plan becomes insolvent. Second, it looks at measures designed to ensure that consumers are not harmed in the event that a plan does fail.

### **Protection against Insolvency**

Plans become insolvent primarily because of errors in assessing and managing risk. These errors could be caused by adverse risk selection, unanticipated increases in utilization, the inability to control utilization, or other factors that leave plans with insufficient resources to cover the cost of benefits provided.

Although there is little information on PSO insolvencies, theoretically these organizations face a greater risk of insolvency because some of their characteristics are associated with higher failure rates. As noted above, PSOs are generally smaller than HMOs not owned by providers, in terms of both financial resources and numbers of enrollees. Further, PSOs are younger organizations with more limited experience in risk management. In the absence of offsetting (risk-reducing) characteristics, these factors tend to make PSOs more prone to solvency problems.

This section describes existing solvency protection and discusses an approach being developed to establish solvency requirements for all risk-bearing health plans, including PSOs. Because the majority of states lack explicit standards for PSOs, most of the discussion on existing protection focuses on standards for HMOs.

***Insolvency Protection for HMOs.*** Most states have established a number of financial requirements intended to reduce the prospects of plan insolvency. For the most part, these requirements are based on standards in NAIC's HMO model act. Medicare has a general requirement that plans demonstrate a fiscally sound operation, but its rules are not as specific as those of most states.

***The NAIC HMO Model Act.*** The HMO model act contains several requirements designed to prevent insolvency. A plan must have a minimum initial net worth of \$1.5 million. Once in operation, it must maintain a minimum net worth equal to at least \$1 million or a percentage of annual premium revenues (2 percent of the first \$150 million in premium revenues and 1 percent of higher amounts), whichever is greater.<sup>12</sup>

---

<sup>12</sup> A plan's net worth must also be greater than an amount sufficient to pay three months of uncovered health expenditures and greater than a percentage of annual hospital payments (the sum of 8 percent of noncapitated or nonmanaged payments and 4 percent of capitated or managed payments).

In addition to the net worth requirements, a plan must deposit \$300,000 either with the insurance commissioner or with an organization or trustee acceptable to the insurance commissioner. This deposit is allowed as an asset for determining the plan's net worth.

Finally, if a plan's uncovered expenditures exceed 10 percent of total health expenditures, it must deposit an additional amount (120 percent of the estimated liability for uncovered expenditures) with the state insurance commissioner.<sup>13</sup>

**State Standards for HMOs.** Most states have adopted these NAIC requirements. Almost all states require deposits with the insurance commissioner and some level of minimum net worth. There is considerable variation, however, in the amounts and definitions specified under these requirements. Deposit requirements range from \$50,000 in California to \$1 million in Kentucky.<sup>14</sup> Similarly, the initial net worth standard is set as low as \$100,000 (Michigan) or as high as \$6 million (New Hampshire). Many states also mandate participation in guaranty funds or the maintenance of other surplus funds. There may be some trade-offs among these different requirements.

This wide variation in HMO solvency requirements may reflect differences in the prevalence of managed care among states. States with more HMOs may perceive that high solvency requirements are not needed because consumers would be able to obtain comparable coverage quickly if their HMO failed.<sup>15</sup> In states with less experience with managed care, however, higher solvency standards may be more appropriate.

States use two tools to determine if plans comply with solvency requirements. First, they look for signs of financial distress in the annual financial statements filed by plans. Second, they send someone to visit the plan to assess whether data in the statements are accurate and if the plan seems to be at risk (Klein and Barth 1995). In addition, other information, such as historical plan financial databases maintained by NAIC, is used to help determine which plans need a closer look.

A number of concerns, however, have been raised about how adequately these monitoring efforts determine a plan's financial health and avert its failure. Data on annual filings may not be accurate enough or available in time to signal financial duress (Finch 1991). Some believe that, besides reviewing assets, regulators should examine such factors as a plan's managerial skill, network design, market position, and reputation (Akula 1997).

When financial problems exist, states may not act quickly enough to keep a mildly distressed plan from experiencing more serious problems. For example, the failure of Blue Cross and Blue Shield of West

---

<sup>13</sup> Uncovered expenditures are for services (e.g., out-of-area services and referral services) that the plan does not furnish directly and for which contractual arrangements with nonnetwork providers do not exist.

<sup>14</sup> See Aspen Systems (1996) for a complete comparison of state solvency requirements.

<sup>15</sup> Some states even require competing HMOs to accept enrollees from a failed HMO on a space-available basis.

Virginia in 1990 has been blamed in part on state delays in taking actions once it became apparent that the plan had financial and management problems (GAO 1994).

A further concern is that some states may not have the resources to monitor plan compliance effectively. According to a 1991 survey, only 28 states could even identify how many staff members were involved in regulating health insurance; of those, 9 states reported having fewer than 10 with regulatory responsibilities (GAO 1993).

**Medicare Standards for HMOs.** The Social Security Act requires that plans make adequate provision against the risk of insolvency. Implementing regulations include such general rules as having a sufficient cash flow and adequate liquidity to meet obligations as they become due and a net operating surplus. Medicare's requirement that plans have a state license apparently has reduced its need to specify net worth and reserve requirements.

There is recent precedent for waiving the license requirement, although not for eliminating a state role entirely. One plan selected to participate in the Medicare Choices demonstration is the first PSO to do so without having a state HMO license. (Other PSOs in the demonstration have HMO licenses.) The Florida Hospital Healthcare System operates as a Medicare-only plan, and it has obtained a letter of understanding from Florida's insurance department acknowledging that it may operate without a license (see Chapter 2).

**Insolvency Protection for PSOs.** When states regulate PSOs under existing HMO statutes, HMO solvency requirements apply to the PSOs. But, as discussed above, some states have put in place specific rules for PSOs. For the most part, the solvency requirements in these PSO-specific regulations appear to be equivalent to or somewhat lower than those for HMOs. For example, Kentucky's law calls for PSOs to meet a solvency requirement of \$1.5 million and to maintain a net worth of either \$1 million or 2 percent of annual premium revenues. Similarly, as a result of creating a new regulatory track in 1996, Georgia's PSOs will be required to have a net worth of \$1 million.

**Issues in Applying HMO Solvency Standards to PSOs.** A fundamental difference between PSOs and most HMOs is that PSOs provide services directly rather than act as an intermediary organization between beneficiaries and other providers. The characteristics of PSOs have raised several issues about the appropriateness of applying HMO solvency requirements to PSOs.

**Insurance Risk or Service Risk.** The first issue concerns whether PSOs are incurring insurance risk and thus whether they should be subject to any solvency standards—at least when they are in a downstream relationship with a licensed health plan or an employer plan. Although all insured plans are subject to state solvency standards, groups like the AHA have argued that, since most PSOs provide services directly, they incur no insurance risk (AHA 1995; Hirshfeld 1996).<sup>16</sup> The argument

---

<sup>16</sup> Insurance risk is generally defined as the transfer of risk from one party (the insured) to another (the insurer) and the distribution of actual losses across a large pool of people with similar risks (NAIC 1996).



PSOs make is that they are incurring service risk rather than insurance risk, in much the same way that a warranty corporation enters into a prepaid contract to maintain an automobile or home heating system.

After reviewing advisory letters from state insurance commissioners, however, NAIC concluded that many PSOs are engaged in the business of insurance and thus should be subject to solvency standards (NAIC 1995).<sup>17</sup> Specifically, if the PSO is accepting payments on a capitated basis, other than in a downstream capacity with a licensed plan, then it is engaged in accepting insurance risk.

An alternative view strikes a middle ground between the AHA and NAIC positions. According to this view, the complexity and expense of delivering modern medical care make it impossible for PSOs to act solely as service corporations. But they may be closer to these entities than to insurers that simply pay providers (Overbay and Hall 1996). As illustrated by two polar examples, the key is the share of services directly provided by the PSO. If the PSO directly provides 100 percent of the services for which it is contractually at risk, then the PSO could be considered a service corporation. But if the PSO does not provide any services directly, then it is no different from an insurer and would be subject to the same solvency standards. Most PSOs, of course, would fall between these extremes.

Some HMOs, especially staff-model organizations, complicate the picture. Like PSOs, these HMOs provide services directly. Under the distinctions drawn by some provider groups, these HMOs would be incurring only service risk and thus might be exempt from solvency requirements. But doing so would remove some of the consumer protection that exists under the existing state regulatory structure.

**Equal or Lower Solvency Requirements.** A second issue is whether PSOs should have lower solvency requirements than HMOs. Some argue that, all other things equal, a PSO would have lower risk exposure than an HMO acting in an intermediary capacity because it does not face the financial risk for covering the entire cost of services. In the event of temporary cash shortfalls, providers contracting with the HMO would continue to require payment in full for services. By contrast, a PSO's providers would be more likely to deliver services, even at dramatically discounted rates. This commitment to defer (or completely forgo) compensation would reduce the risk of insolvency for PSOs.

Alternatively, PSOs may be inherently more prone to solvency problems than HMOs. As noted above, PSOs exhibit many of the same characteristics of other small businesses (i.e., limited financial assets and experience). Although there are no systematic analyses of PSOs, industry experts indicate that PSOs—like small businesses in other industries—may have potentially higher failure rates (Kertesz and Wojcik 1994; Matheny 1995; Cain 1996; Deogun 1996). Some experts observe that, if providers

---

<sup>17</sup> The distinction between bearing service risk or insurance risk is not always clear-cut and is often decided by the courts.

market predominantly to their patients, PSOs may find that they have higher-risk enrollees than other plans and that capitation payments could be inadequate to pay the cost of care (Schorr 1997).

Furthermore, it is unclear whether providers will uphold their commitment to continue delivering services in case of cash shortfalls. Contractual obligations may be of little use to beneficiaries because providers cannot be compelled to provide services. Beneficiaries' primary recourse would be to file suit for monetary damages. In theory this should compensate them fully for the loss of medical care or the out-of-pocket liability incurred for purchasing services. In practice, however, that may not be the case. First, some beneficiaries may have difficulty getting care when it is needed. More generally, beneficiaries would be immediately liable for the cost of care and would receive compensation only after a lengthy legal process.

**Admissibility of Health Care Delivery Assets.** Finally, a third issue concerns the extent to which health care delivery assets are admissible (allowable) for satisfying solvency requirements. These assets include physical property and equipment used to provide medical care. According to a survey, all states regulating HMOs allow delivery assets to count toward satisfying solvency requirements (American Academy of Actuaries 1996). Most states, however, limit the amount of health care delivery assets that are admissible for solvency purposes. Illinois, for example, limits furniture and equipment to 30 percent of admissible assets and real estate to 20 percent. Minnesota limits all delivery assets to 30 percent.

Limits on admissibility of assets are typically based on two considerations. First, delivery assets may not be fully liquid. It may be difficult to convert them into cash to cover temporary financial shortfalls. Second, unlike the value of other types of assets, the value of health care delivery assets may be affected by the insolvency. An asset's value is based on both its resale value and its estimated future use. If a plan reduces services due to financial shortfalls, the value of this asset may drop. For example, lowering the number of images made on the plan's MRI to save costs would also diminish the revenue stream from that device and thus the value of the device itself.

Provider organizations argue that health care delivery assets should be fully admissible. These assets appear to account for a larger share of total assets for PSOs compared with HMOs. As noted earlier, about 30 percent of assets for provider-owned HMOs was in physical property and equipment, whereas property and equipment accounted for only about 5 percent of assets for other HMOs. Excluding some delivery assets, according to PSOs, would in effect subject them to higher solvency requirements. PSOs could achieve the same distribution of assets as other plans by selling off some of their delivery assets and investing the proceeds in assets not related to delivery. Such actions, though, could undermine efficiencies that PSOs might achieve by concentrating their assets in capital related to health care delivery.

In sum, the critical issue highlighted by these concerns is ensuring that solvency standards do not favor one organizational structure over another. Whether these standards are high or low, they should be applied to all plans equitably.

**An Alternative Approach to Solvency Standards: Risk-Based Capital.** Traditionally, states have set reserve requirements without explicitly recognizing the amount of actual risk exposure faced by various types of insurance plans. This approach may not be appropriate for the wide range of organizations known as PSOs.

In 1993, NAIC established a working group to develop an alternative approach to setting capital reserve requirements for health plans. The intent of risk-based capital is to link plan financial reserve requirements to the amount of risk assumed, rather than to the structure or name of the organization. Each plan would then have to satisfy a reserve requirement tailored to its risk exposure.

For purposes of calculating risk-based capital requirements, NAIC has assigned the sources of risk into four categories, which it labels C-1 through C-4:

- asset risk (C-1): the risk that a plan's assets could lose value either through default or other reductions in market value;
- insurance risk (C-2): the risk of loss if actual claims exceed expected claims, due to random fluctuations and inadequate pricing;
- interest risk (C-3): reductions in plan assets due to changes in interest rates; and
- business risk (C-4): the overall risk of business failure.<sup>18</sup>

A risk-based capital requirement is calculated by adjusting these risk factors to account for risk-reducing (or increasing) actions taken by the plan. For example, managed-care credits are applied to insurance risk if the plan establishes fee schedules, engages in risk sharing (e.g., partial and full capitation), or restructures its cost basis (e.g., salaries and negotiated budgets). In this fashion, plans with lower risks would have lower capital reserve requirements.

Currently, NAIC is pilot testing draft risk-based capital rules with a large group of HMOs. The working group expects to complete action on this initiative by the end of 1997.

### **Consumer Protection in Case of Plan Failure**

Whereas financial reserves and deposits are designed primarily to keep plans solvent, other regulations are crafted to protect consumers from the adverse consequences of plan failure. As elsewhere in this chapter, this section examines state and federal regulations initially applicable to HMOs and then considers their relevance for PSOs.

---

<sup>18</sup> Interest risk (C-3) is a greater concern with life insurers, where policyholders could respond to changes in interest rates by withdrawing funds from the insurer.



**Consumer Protection for HMO Enrollees.** From the enrollee's perspective, a plan's financial solvency ensures that it will be able to fulfill its obligation to provide or pay for needed health care. Federal Medicare regulations and the HMO Act include measures to make certain that HMOs are financially sound and that, in case of insolvency, enrollees are not held liable for payments that are the legal obligation of the HMO. These include requirements to ensure that funds are available to pay for care (insolvency insurance) and that care is delivered without further cost to enrollees (continuation of coverage agreements or hold-harmless clauses). Federal requirements are explicitly waived where states already provide adequate protection.

Most states have adopted these same types of requirements. In addition, some states also require HMOs to file contingency plans that describe how they would settle claims and provide services during an insolvency (Center for Health Care Rights 1995; Aspen Systems 1996).

**Insolvency Insurance.** Most states require HMOs to have some type of insolvency insurance coverage. Such insurance is designed to ensure that enrollees continue to receive care during insolvency proceedings, until they can obtain alternative coverage. It does so by making funds available for at least partial payment to providers for services delivered between the time the plan becomes insolvent and the end of the coverage period.<sup>19</sup> In addition to requiring insolvency insurance, states also consider such arrangements when assessing whether an HMO is financially sound.

**Continuation of Coverage.** Another approach to consumer protection is to require HMOs to continue enrollees' health coverage beyond the date of insolvency. Beneficiary advocates point out that both insolvency insurance and continuation of benefits provisions are necessary to protect enrollees. Unless an HMO has some way to pay for continued coverage of health services, a mandate to continue coverage is an empty promise to enrollees of an insolvent HMO (Center for Health Care Rights 1995).

More than half the states require HMOs to continue coverage of benefits in at least some limited manner in the event of insolvency. States typically require HMOs to provide for the continuation of benefits for the duration of the period for which enrollees' premiums have already been paid. Many also require that, for enrollees hospitalized at the time of insolvency, the HMO must continue benefits until discharge. Some states limit liability to a specific period of time. Rhode Island, for example, requires continuation of benefits for 90 days for enrollees receiving services in any type of health facility and 30 days for all other enrollees.

An alternative approach is to require all other insurers in the insolvent HMO's service area to offer the enrollees of the insolvent HMO the opportunity to purchase coverage. In addition, some states require that no medical underwriting restrictions be applied to this offer of coverage. Almost half of the states have such continuation of benefits provisions (Center for Health Care Rights 1995).

---

<sup>19</sup> Some states use the term reinsurance for this type of coverage. Although reinsurance more typically refers to insurance an HMO purchases to cover services for high-cost enrollees, such agreements may also insure the cost of covered services in the event of insolvency.

**Hold-Harmless Clauses.** Some states also protect consumers through hold-harmless clauses. If an HMO becomes insolvent or, for another reason, fails to pay its contracting providers for services rendered, enrollees are not liable for the cost of services normally covered by the HMO. Hold-harmless clauses thus prohibit providers from collecting payment from enrollees of the insolvent plan. Together with continuation of coverage agreements, these measures are designed to ensure that enrollees can still receive covered services without being liable for their costs.

Almost all states include a hold-harmless provision in their HMO laws. Most require that all contracts between the HMO and the provider include hold-harmless clauses and prohibit providers from collecting additional amounts from enrollees. Some states that do not require these provisions recommend that plans adopt them (Center for Health Care Rights 1995).

**Life-Health Guaranty Associations.** A final measure adopted by some states addresses situations where plan funds or insolvency insurance are inadequate. State life-health guaranty funds are sometimes used to protect enrollees in these circumstances. They usually operate by assessing other health insurers to cover the insolvent carrier's shortfall. Although traditionally associated with protecting consumers from indemnity insurance insolvencies, a handful of states require HMOs to participate in guaranty associations. Guaranty funds can serve as a substitute for hold-harmless and continuation of coverage agreements, since they typically pay benefits to policyholders and provide limited continuation of coverage (Butler and Polzer 1996).

**The Effectiveness of Insolvency Protection Measures.** How adequately regulatory measures protect consumers when plans become insolvent is uncertain. The measures discussed in this section are generally contractual agreements between the plan and its enrollees or between the plan and its providers. In theory and on paper, consumers appear adequately protected from the adverse consequences of plan failure. Questions about the enforcement of contractual obligations, access to noncontractual care, and the ability to collect payment are raised, however, when plans actually fail.

When a plan becomes insolvent, several outcomes are possible. The most likely outcome is that the plan is taken over by a rival either through merger or acquisition. Second, the plan could file for temporary relief from paying its creditors with the hope of regaining solvency through a combination of reorganization and cost-cutting steps. Finally, the plan could be liquidated, with the funds received from the liquidation distributed to the outstanding creditors.

There is little evidence that consumers are necessarily worse off when their plan is merged or acquired. In fact, a primary objective of the acquiring plan is generally to increase its market share. Any steps taken that may create dissatisfaction (e.g., discontinuity of care), therefore, could result in more disenrollments.<sup>20</sup>

---

<sup>20</sup> The experience of the International Medical Centers (IMC) failure and subsequent acquisition by Humana provides a case in point. Until its contract was terminated by HCFA in 1987, IMC was the largest Medicare risk contractor, with some 136,000 enrollees in south Florida. For several years prior to its failure, the plan delayed payments to providers. In response, a number of local hospitals and medical specialists refused to continue providing care to IMC enrollees (GAO 1986; Committee on Government Operations 1988). After Humana acquired the plan, however, there were far fewer reports of these sorts of problems.



Various surveys of state regulators and industry experts have found that consumer protection measures appear to work well in instances of outright plan failure. A 1988 survey of state regulators found that almost all of 21 HMOs that became insolvent over a seven-year period had adequate enrollee protection through insolvency insurance and hold-harmless clauses (Stone and Heffernan 1989). A more recent survey of regulators also found that the combination of hold-harmless provisions and the ability of states to move enrollees quickly into solvent plans appeared to protect enrollees from financial liability and coverage gaps (Levitt and Claxton 1996).

Even so, these measures have not always worked as well as intended. In 1989, for example, Maxicare and 47 affiliated health plans filed for protection under Chapter 11 of the U.S. Bankruptcy Code. At that time, these plans covered about 2.4 million enrollees in 25 states and had about \$1.4 billion in liabilities (Branch and Fitzgerald 1990). Although contracted providers abided by the hold-harmless provisions in their contracts, other providers (i.e., those providing out-of-plan specialty or emergency care) were under no similar obligations. Instead, the noncontracting providers initiated collection actions against enrollees. Eventually, the bankruptcy court enjoined these providers from pursuing their collection efforts.

A similar situation occurred in the 1990 failure of Blue Cross and Blue Shield of West Virginia (an indemnity plan). Because the plan did not belong to the state's guaranty fund, almost 50,000 policyholders were left with about \$40 million in unpaid claims when the plan failed.<sup>21</sup> Further, many providers held these policyholders liable for these claims (GAO 1994).

**Applying HMO Solvency Protection to PSO Enrollees.** In the Commission's view, enrollees of different types of health plans should have similar protection under the law. Yet there is a difference in how protection may work with a PSO, given that its owners are typically also its providers. Continuation of coverage provisions could be easier to enforce, since the plan owners provide many of the services. But, as discussed above, even the provider-owners need to get paid at some point—making it important that funds are available to do so. In addition, contractual obligations may be difficult to enforce and sometimes might require enrollees to take legal action before restitution is made.

Unless there is reason to believe that PSO enrollees would fare differently than HMO enrollees in the event of a plan insolvency, hold-harmless clauses and insolvency insurance should be applied to PSOs in order to give equal protection to all managed-care enrollees. Together with appropriate financial reserve and deposit requirements, these measures create a blend of protection necessary for PSO enrollees.

---

<sup>21</sup> Most states exempt Blue Cross Blue Shield plans from guaranty fund participation.



## A FEDERAL POLICY PERSPECTIVE

In 1995, the treatment of PSOs became a key issue for both the Congress and the Administration, as they drafted their respective versions of Medicare restructuring legislation.<sup>22</sup> It is certain to be an important issue again when the 105th Congress takes up Medicare legislation.<sup>23</sup> This final section reviews the treatment of PSOs in the 1995 legislative proposals and concludes with the Commission's recommendations on how PSOs might be addressed in future debates.

### Congressional Debate over 1995 Medicare Legislation

Both the Congress and the Administration produced versions of Medicare legislation in 1995 that anticipated some need for special treatment of PSOs.<sup>24</sup> For example, provisions in the Balanced Budget Act of 1995 (H.R. 2491), passed by the Congress in November 1995 but vetoed by the President, would have given plans offered by PSOs special rules with respect to certain requirements that otherwise would apply to all participating health plans. These included waivers of state licensure requirements, separate solvency standards, and minimum enrollment requirements.<sup>25</sup>

Waiving state licensure requirements responded to the concerns of PSOs that state agencies may delay applications or fail to acknowledge differences between PSOs and traditional health plans. The Balanced Budget Act offered waivers of state licensure requirements to all types of plans in the case of delays or the imposition of unreasonable barriers to market entry. It defined additional circumstances under which PSOs could request a waiver, specifically, if the state imposed requirements or standards not generally applicable to any other entities engaged in substantially similar business.

In addition, proposals by the Congress and the Administration would both have applied solvency standards differently to PSOs than to other plans participating in Medicare. The Administration proposal required the Secretary to develop separate solvency standards for PSOs. It would have preempted state laws on fiscal soundness and solvency if they differed from those imposed on other organizations, unless the state standards were approved by the Secretary. The Secretary would have been required to consult with NAIC and other interested parties to develop standards.

---

<sup>22</sup> See a report on PSOs by the Congressional Research Service (1996) for a side-by-side comparison and analysis of these provisions.

<sup>23</sup> As of March 1997, legislation had already been introduced that would set standards for PSOs participating in Medicare.

<sup>24</sup> The Administration proposal specifically defined a PSO as a hospital, group of affiliated hospitals, or affiliated group consisting of a hospital or hospitals and physicians, which provides at a minimum physicians' services and inpatient hospital services and directly provides a substantial portion of covered services. The Balanced Budget Act defined a PSO as a public or private entity (1) that is established or organized by a health care provider or group of affiliated providers, (2) that provides a substantial proportion of health care services directly through the provider or affiliated group of providers, and (3) where the affiliated providers that share substantial financial risk with respect to the provision of services have at least a majority financial interest in the entity.

<sup>25</sup> The Balanced Budget Act would have reduced the minimum enrollment requirement for PSOs from 5,000 members (1,500 in rural areas) to 1,500 members (500 in rural areas).

The congressional proposal also assigned to the federal government responsibility for developing and enforcing solvency standards for PSOs participating in Medicare—even though it generally assigned enforcement responsibilities for other plans to the states. This decision apparently responded to the concerns of PSOs that state agencies may not treat them promptly or fairly. The Secretary would have developed solvency standards in consultation with NAIC.

An important difference between the Administration and congressional proposals was that the latter would have required PSOs that participate in Medicare to enter into full-risk contracts, whereas the former would have allowed partial-risk contracts. The Administration proposal called for development of appropriately modified standards to account for the differences between full-risk and partial-risk contracts. The congressional proposal would have required PSOs to be at risk for all services in the Medicare benefit package, including those (e.g., durable medical equipment or home health services) for which subcontracting arrangements may be necessary.

In the legislative process that led to the conference agreement on the Balanced Budget Act, the House and Senate versions differed considerably on the treatment of PSOs in Medicare. These different positions suggest some of the perspectives that might reemerge in a future legislative debate.

The Senate version included a general requirement that all plans obtain state licenses, similar to the requirement in current law. PSOs were specifically mentioned as eligible organizations, but no special provisions were included for PSOs. The Senate version also provided temporary federal certification of any plan wishing to participate in Medicare, if it were unable to obtain a license because of unreasonable delay or the creation of barriers to market entry.

The House version, by contrast, generally exempted PSOs participating in Medicare from the requirements of state regulation and called for the development of separate federal standards for PSOs, with the proviso that they be as consistent as possible with those for other plans. These standards would have been developed in a negotiated rulemaking process. Whereas the conference agreement called for separate standards only for solvency and minimum enrollment, the House bill would have developed a full set of separate standards for PSOs. In addition, the House bill called for federal certification of PSOs unless a state showed that its standards were identical to federal ones.

### **Addressing PSOs in Future Legislative Debates**

Much of the legislative activity in 1995 reflected concerns that state regulatory structures were not designed with PSOs in mind, and thus discouraged their growth. The approach taken in both proposals (although not in the original House legislation) generally relied on an exceptions or waiver process. In the area of solvency standards, however, the approach was development of federal rules that would preempt state rules except when a state's rules were approved by the Department of Health and Human Services.

The Commission, in its 1996 report, took a more general approach (PPRC 1996). The recommendation called for applying the same standards to all plans, while noting the need for flexibility because of differences in plan design. The call for flexibility recognized, for example, that appropriate net worth and deposit requirements might be different for a PSO that owned the delivery assets than for an insurer-owned HMO that contracted out delivery of all health care services. But the Commission did not specify whether flexibility might be best accomplished through a waiver process, a new set of federal rules, or a reworking of certain state rules.

**A Changed Environment.** The context of 1997 differs from that of 1995 in several ways. States are starting to make the adjustments necessary to ensure that PSOs do not face unnecessary barriers to market entry. In addition, whether under old or revised regulatory structures, PSOs in many markets have been succeeding. Together, these trends may suggest a different approach to federal legislation. Whereas the 1995 proposals generally assumed that state regulations were a significant obstacle, it may be reasonable in 1997 to assume that states are moving in an appropriate direction. As discussed below, such a conclusion could simplify the task for the Congress in drafting legislation.

PSOs in various forms are thriving in many markets (Votz and Cochrane 1996). In some markets, provider groups are creating new entities, obtaining HMO licenses, and successfully enrolling members. The early success of California Advantage, formed by the California Medical Association, and the emergence of a plan based at the University Hospitals Health System in Cleveland are two of many examples that have been cited. In other markets, provider groups are taking a more active role as subcontractors to HMOs or self-insuring employers. These include cases (e.g., Harvard Pilgrim in Boston and CIGNA in Los Angeles) where traditional staff-model HMOs are divesting their provider groups—which then form PSOs. They also include markets such as Minneapolis-St. Paul, where employers are offering provider-run care systems—best described as PSOs—in place of HMOs. These examples make it difficult to argue that the growth of PSOs is seriously threatened by existing state laws.

Second, as noted above, some states are modifying their regulatory environments. A few have passed new legislation explicitly recognizing PSOs as distinct organizational structures. Others have worked less formally with PSOs to make adjustments in existing rules. Regulators in two states told the Commission in expert panel meetings about discussions they held with new PSOs. The conclusion in these cases was that financial solvency requirements were the only significant obstacle in existing law and that there was adequate room to reach accommodations on that issue.

Third, NAIC is moving forward with its new model laws. Typically, it only approves new models after extensive negotiation with interested parties, in addition to achieving a degree of consensus among the insurance commissioners themselves. At present, provider groups like the AHA remain skeptical that a compromise can be achieved, especially by any particular date. Ideally, the Congress will have a chance to review these new models before it passes Medicare legislation. Given that the past legislative proposals would have asked NAIC to help develop standards, it seems reasonable to look to NAIC action as a key milestone.



Fourth, antitrust considerations loomed large in 1995 as an obstacle to the formation of PSOs. The 1996 issuance by the Department of Justice and the Federal Trade Commission of a new set of statements concerning antitrust enforcement policy in health care appears to have substantially allayed providers' concerns (see Appendix A).

Taken together, these trends seem to reduce the urgency of special treatment for PSOs in federal Medicare legislation. For example, if NAIC adopts model acts that are seen as addressing some of the more serious concerns, it would be simpler for the Congress to urge states to adopt those models than to develop and promulgate separate federal standards. Given that numerous PSOs have been started and that many have been able to get HMO licenses without modified standards, the likelihood that PSOs will have difficulty getting into the Medicare program appears smaller than it did two years ago.

**PSOs and Medicare.** PSOs that hold HMO licenses have participated in the Medicare risk program for a decade or more. HCFA, through the Medicare Choices demonstration, is actively seeking to bring more PSOs into Medicare. As noted above, several PSOs have started enrolling beneficiaries, including one without an HMO license.

For some PSOs, the enrollment composition requirement (the so-called 50-50 rule) is viewed as an obstacle to participation in Medicare. The rule, which requires that no more than half of plan enrollees be Medicare or Medicaid beneficiaries, has been viewed as an indirect measure of plan quality and experience. Many provider-based plans prefer not to compete in the commercial market, especially in communities where they have existing relationships with health plans that would be their competitors.

The Commission has taken a position that the 50-50 rule will become unnecessary when an enhanced quality assurance system that incorporates health plan performance measures is in place (see Chapter 7). Once this change is made, PSOs and other plans will have the opportunity to compete for beneficiaries on a Medicare-only basis. Provider groups argue that Medicare-only plans should not be subject to state licensure or regulations, and that a new set of Medicare regulations should be developed for these plans (although they would use existing state agencies to enforce the federal standards). Existing Medicare standards would generally require more detailed implementing regulations than at present, and some would prefer to see certain rules modified in these circumstances. Other groups, including the HMO industry, contend that doing so would require increased federal staffing to develop and enforce these rules.

**The Commission's Recommendations.** The Commission this year reiterated its support of the general principle that all plans that contract with Medicare should be subject to the same standards, as well as its position that some flexibility may be necessary to accommodate differences in plan design. It added a specific call to monitor plan participation in Medicare to ensure that the rules, however structured, do not prevent qualified organizations from entering the Medicare market.

The Commission's support for equal treatment for all types of plans could be implemented in several different ways. One option would maintain the current requirement that all plans obtain state licenses.

This decision would assume that states, with the help of new NAIC models, would continue to adjust requirements in light of the emergence of new types of plans. Federal monitoring of plan participation would be important. The Congress could also consider monitoring state licensure laws, as it does under the HMO Act, for evidence of provisions that inappropriately deter the entry of new plans.

A second approach could be to replace state standards with uniform federal standards that apply to all Medicare-contracting plans. HMOs, PSOs, and other types of plans would all be subject to these new rules, perhaps using state agencies for enforcement. Although this approach would ensure equal treatment and make Medicare the standard-setter for its contractors, it would transfer to the federal government a role that historically has been granted to the states.<sup>26</sup>

Regardless of how accomplished, an important benefit of treating all plans equally in federal legislation is that it lessens the need for the Congress to become enmeshed in a series of technical and definitional issues, especially around definitions of PSOs. For example, issues in the last legislative cycle included what providers would be considered to be owners or what portion of services must be delivered by the provider-owners. Equal treatment would also avoid the need to spell out precise criteria under which waivers would be made available, the length of time a waiver would be valid, or the terms for renewing a waiver.

Another benefit to applying the same standards across plans would be to ensure that Medicare beneficiaries enrolling in PSOs receive the same protection as those in other types of plans. As described earlier in this chapter, the early rise of HMOs was followed by some well-publicized plan failures and the conclusion that lack of capital and managerial experience were partially to blame. As PSOs grow in popularity, some experts raise similar concerns that they may lack adequate managerial experience or capitalization. If true, both consumers and providers could be placed at risk. Applying the rules that have generally worked in the past—especially with the modifications being developed by the states—should help to protect beneficiaries without imposing substantial barriers to market entry.

## REFERENCES

- Advisory Board, *The Grand Alliance: Vertical Integration Strategies for Physicians and Health Systems* (Washington, DC: 1993).
- Ahern, Melissa, "The Evolution and Impact of State HMO Regulation: A Case Study," *Journal of Insurance Regulation* 10(1):110-127, Fall 1991.
- Akula, John L., "Insolvency Risk in Health Carriers: Innovation, Competition, and Public Protection," *Health Affairs* 16(1):1-25, January/February 1997.

---

<sup>26</sup> Some have suggested that federal rules be applicable to Medicare-only plans once the 50-50 rule is eliminated. Others object that this approach would exempt some plans from the protection of state laws—and would require a full set of federal rules and a means of enforcement for relatively few plans.

- American Academy of Actuaries, *Final Report to the National Association of Insurance Commissioners Health Organizations Risk-Based Capital Working Group* (Washington, DC: June 1996).
- American Association of Physician-Hospital Organizations, *1995/1996 Profile of Physician-Hospital Organizations and PHO Executives* (Glenn Allen, VA: 1996).
- American Hospital Association, "Regulation of Health Plan Companies and Provider Sponsored Networks: Practical and Public Policy Considerations," draft memorandum, April 1995.
- American Hospital Association, "Provider Sponsored Organizations: New Approaches to Managed Care," memorandum, July 1996.
- Aspen Systems Corporation, *A Report to the Governor on State Regulation of Health Maintenance Organizations*, 16th edition, report to the Health Care Financing Administration, Office of Managed Care, under Contract No. 500-95-0037 (Rockville, MD: 1996).
- Branch, Joseph C., and Kevin G. Fitzgerald, "HMO Insolvency: Implications of the Maxicare Decisions," *Torts and Insurance Law Journal* 25:766-784, August 1990.
- Butler, Patricia, and Karl Polzer, *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law, Special Report* (Washington, DC: National Health Policy Forum, June 1996).
- Cain, Daniel M., "Provider Sponsored Organizations: Potential Benefits and Risks for Physicians," *Group Practice Journal* 45(1):59-61, January/February 1996.
- Center for Health Care Rights, *Consumer Protections in State HMO Laws, Volume I: Analysis and Recommendations* (Los Angeles: November 1995).
- Coile, Russell C., "PHOs Are 'Training Wheels' for PSN Direct Contracting," *Health Care Trends* 8(2):2-3, December 1995.
- Committee on Government Operations, U.S. House of Representatives, *Medicare Health Maintenance Organizations: The International Medical Centers Experience*, House Report 100-568 (Washington, DC: April 14, 1988).
- Congressional Research Service, *Medicare Restructuring and Provider Sponsored Organizations (PSOs)*, No. 96-921 EPW (Washington, DC: November 12, 1996).
- Deloitte & Touche LLP, *U.S. Hospitals and the Future of Health Care* (Washington, DC: 1996).
- Demkovich, Linda, "Fighting Fire with Fire: Doctors Start Their Own HMOs," *State Health Notes* 17(220):1-3, January 22, 1996.
- Deogun, Nikhil, "Network of Doctors, Touted as a Panacea, Develops Big Problems," *Wall Street Journal*, September 26, 1996, p. A-1.
- Ernst & Young LLP, *Physician-Hospital Organizations: State Regulators Play Catch-up* (Washington, DC: 1994).
- Ernst & Young LLP, *PHOs: Physician-Hospital Organizations Profile 1995* (Washington, DC: 1995).



- Ernst & Young LLP, *Navigating Through the Currents* (Washington, DC: 1996).
- Finch, Johnny C., General Accounting Office, written statement to the Committee on Commerce, Science, and Transportation, U.S. Senate, Washington, DC, February 27, 1991.
- General Accounting Office, *Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations*, GAO/HRD86097 (Washington, DC: July 1986).
- General Accounting Office, *Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources*, GAO/HRD-94-26 (Washington, DC: December 1993).
- General Accounting Office, *Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight*, GAO/HEHS-94-71 (Washington, DC: April 1994).
- Group Health Association of America, *PHOs and the Assumption of Insurance Risk: A 50-State Survey of Regulators' Attitudes toward PHO Licensure* (Washington, DC: July 10, 1995).
- Hirshfeld, Edward B., "Assuring the Solvency of Provider-Sponsored Organizations," *Health Affairs* 15(3):28-30, Fall 1996.
- Hoechst Marion Roussel, *Managed Care Digest Series, Medical Group Practice Digest* (Kansas City, MO: 1995).
- InterStudy, *The InterStudy Competitive Edge* 4(1) (Minneapolis, MN: 1994).
- InterStudy, *The InterStudy Competitive Edge, Part II: Industry Report* 5(1) (Minneapolis, MN: 1995).
- Jaklevic, Mary Chris, "PHOs Fall Short of Expectations," *Modern Healthcare* 25(41):77-82, October 9, 1995.
- Kertesz, Louise, and Joanne Wojcik, "Risky PHOs' Winning Bet," *Modern Healthcare* 24(30):44-48, July 25, 1994.
- Klein, Robert W., and Michael M. Barth, "Solvency Monitoring in the Twenty-First Century," *Journal of Insurance Regulation* 13(3):256-301, Spring 1995.
- Levitt, Larry, and Gary Claxton, *A Review of Health Maintenance Organization Solvency Issues*, report to the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (Fairfax, VA: Lewin-VHI, Inc., April 1996).
- Matheny, Meg, ed., "Provider-Sponsored Networks: Easing Capital Requirements Doesn't Guarantee Success," *Health System Leader* 2(10):2-3, December 1995.
- Musser, Josephine, National Association of Insurance Commissioners, written statement to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, July 30, 1996.
- National Association of Insurance Commissioners, "Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers, and Other Groups," memorandum, August 10, 1995.

- National Association of Insurance Commissioners, "The Regulation of Risk-Bearing Entities," draft memorandum, December 1996.
- Neel, Joe, "Clark Kent or Superman: The Market Impact of PHOs," in John Reichard, ed., *The 1995 Health Network and Alliance Sourcebook* (Washington, DC: Faulkner & Gray, 1995a).
- Neel, Joe, "MSOs in the Emerging Healthcare Marketplace," in John Reichard, ed., *The 1995 Health Network and Alliance Sourcebook* (Washington, DC: Faulkner & Gray, 1995b).
- Nilles, Karen M., and James M. Jacobson, "The Risk of Bearing Risk: Emerging Insurance and Tax Law Restrictions on Provider Risk Reimbursement," *Group Practice Journal* 45(1):50-58, January/February 1996.
- Overbay, Allison, and Mark Hall, "Insurance Regulation of Providers That Bear Risk," *American Journal of Law & Medicine* 22(2&3):361-387, 1996.
- Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Project HOPE/The Gallup Organization, *Results of the Physician Payment Review Commission's 1994 National Survey of Physicians*, Selected External Research Series, No. 4 (Washington, DC: Physician Payment Review Commission, September 1995).
- Prospective Payment Assessment Commission, *Hospital-Physician Relations: A National Survey of Hospital Chief Executive Officers and Chiefs of Medical Staff*, Intramural Report I-95-02 (Washington, DC: 1995a).
- Prospective Payment Assessment Commission, unpublished tabulations, 1995b.
- Schorr, Burt, "Ernst & Young to Integrated Systems: Be Wary of Medicare Risk," *Managed Medicare and Medicaid News* 26(10):1-3, March 10, 1997.
- Stone, Diane, and Sari Heffernan, "1988 Survey on Regulation of HMOs and HMO Solvency: Findings and Recommendations," *GHAA Journal* 10(1):28-39, May 1989.
- Votz, David, and John D. Cochrane, "The Future of Provider-Sponsored HMOs," *Integrated Healthcare Report*, August 1996, pp. 1-8.

# Consumer Protection Initiatives for Managed Care

Changes in the organization, financing, and delivery of health care services have raised a number of policy issues concerning consumers. With nearly three-fourths of insured American workers enrolled in a health maintenance organization (HMO), a preferred provider organization (PPO), or a point-of-service plan, the rapid growth of managed care has been accompanied by calls for more stringent oversight and regulation from both consumer and provider groups (Jensen et al. 1997). Consumers are concerned about limits on their freedom to seek care from out-of-network providers as well as restrictions on the use of certain specialists and emergency services. Providers have also taken issue with provider network rules, gag clauses, and due process provisions.

Responding to these concerns, policymakers in nearly every state with a significant managed-care presence have considered new consumer protection laws or regulations for managed-care plans (Azevedo 1996). Often referred to as anti-managed-care legislation by opponents and as patient protection acts by supporters, these proposals are typically designed to restrict plans' activities (Hellinger 1996). Any willing provider laws, for instance, require managed-care plans to include in their networks any qualified provider willing to accept their terms and conditions; freedom of choice laws allow managed-care enrollees to receive care from out-of-network providers without excessive financial penalties.

Since the Physician Payment Review Commission last addressed these issues in its 1995 annual report, there has been an unprecedented increase in legislative activity by federal and

*This chapter includes:*

- *Any willing provider, freedom of choice, and direct access laws*
- *Coverage for emergency services*
- *Consumer grievance and appeals procedures*
- *Length-of-stay provisions*
- *Gag clauses and due process measures*
- *Physician financial incentives*



state governments. According to the American Association of Health Plans (AAHP), more than 400 anti-managed-care bills were introduced in state legislatures in 1996—twice as many as in 1995 and four times the number in 1994 (Azevedo 1996). Last year, 39 states passed some form of managed-care consumer protection legislation (Families USA Foundation 1996).

While any willing provider and freedom of choice proposals have received the most attention over the last few years, legislative initiatives are now centering on a second generation of managed-care issues. These include maternity and mastectomy length of stay, physician gag rules, direct access to specialists (primarily obstetrician-gynecologists), access to emergency care, and information needs of managed-care enrollees and those considering enrollment. Other recent initiatives are aimed at strengthening managed-care grievance and appeals procedures for enrollees and due process provisions for physicians.

Driving many of these initiatives are consumers' and providers' perceived threats to access and quality from cost cutting under managed care. Their concern is that HMOs have compromised patient care by making cost cutting a primary goal. Because of compensation arrangements that physicians have with managed-care plans, consumer advocates argue, physicians have an incentive to hold down costs by limiting their services to patients. Anecdotal evidence about delayed or restricted access, or plan refusal to pay for certain services as a result of financial pressures, often provides a stimulus to bring these measures before state legislatures.

In response to these initiatives, the managed-care industry denies that it restricts services, arguing that enrollees in managed-care plans actually receive more comprehensive preventive services compared with those having fee-for-service insurance. They suggest that the increased criticism of managed care is coming from hospitals and physicians who are feeling the financial pinch of managed care. In addition, while the industry admits that there have been some problems with HMOs, it points out that the most egregious ones often cited in support of tougher managed-care regulation can occur in fee for service.

This chapter provides a look at legislative initiatives designed to protect consumers under managed care. It updates the information presented in the Commission's 1995 annual report and expands the focus to include recent trends in legislative measures. Rather than presenting an exhaustive list of all the consumer protection issues addressed by the states, the chapter is intended to highlight some of the more important consumer-related provisions many states are considering. In addition, it summarizes recent federal activities in this area and includes a discussion of the recently created Presidential commission that has been charged with addressing some of these issues.

## STATE AND FEDERAL INITIATIVES

There is considerable variation among the states with respect to managed-care consumer protection legislation.<sup>1</sup> While most states have focused on only one or two areas of consumer concern, a number of states have passed comprehensive consumer protection legislation (Kostreski 1996). Recently, for example, Georgia, Kansas, Maine, New Jersey, New York, Rhode Island, Virginia, and West Virginia passed legislation covering a broad range of managed-care issues (Families USA Foundation 1996). Several of the state bills are modeled after the American Medical Association's (AMA) Patient Protection Act, which (among other things) would require plans to disclose information about their standards of care to patients and providers and to establish written utilization review protocols.

Numerous states will be considering comprehensive consumer protection proposals in 1997. For example, legislators in nine states recently announced their intention to introduce consumer protection legislation based on a model bill designed by Women in Government, a nonpartisan group of state elected officials. Their proposal will address access and quality issues, coverage of experimental treatments, grievance procedures, and appeals.

The Congress has also considered various important consumer protection measures recently. This activity is expected to continue at the federal level, especially in light of the recently announced Presidential advisory commission on consumer protection and quality. While single-issue proposals (e.g., gag rule provisions) are likely to be introduced, a number of comprehensive consumer reform measures are also being brought before the Congress. For example, Representative Pete Stark recently introduced the Managed Care Consumer Protection Act of 1997 (H.R. 337), a bill that addresses several consumer concerns. Among these are grievance procedures, consumer information, coverage of emergency services, access to clinical studies, and restrictions on commissions for managed-care plan sales agents. Senator Edward Kennedy and Representative John Dingell also recently introduced the Health Insurance Bill of Rights Act of 1997 (S. 373/H.R. 820), which would impose a wide range of regulations on managed-care plans, including barring gag rules and protecting against so-called drive-through mastectomies.

### Any Willing Provider Laws

Any willing provider laws require health plans to admit to their networks any qualified provider willing to abide by the terms and conditions of the contract. The industry views these measures as one of the greatest threats to managed care. Opponents of any willing provider laws argue that, because these laws restrict the ability of plans to contract selectively with providers, plans are less able to ensure volume discounts and preserve quality of care (Hellinger 1996). About half the states have any willing provider

---

<sup>1</sup> The initiatives addressed in this chapter are those that states have adopted in addition to traditional HMO regulations. Most HMO licensing acts include provisions relating to fiscal solvency, quality assurance, utilization management, grievance procedures, enrollee benefits, and enrollee information.

laws, most of which were enacted between 1993 and 1995. Recently, legislative activity in this area has ebbed; only a few states have passed any willing provider laws in the last two years.

Any willing provider laws differ in the scope of providers covered. The broadest of these laws compels managed-care plans to accept all providers that agree to their contractual terms. A total of 11 states have passed laws that apply to all or most categories of health care providers. Some states limit the application of these laws to certain specialists or allied health professionals only. The majority of any willing provider laws, however, apply only to pharmacy services.

These laws also differ with respect to the types of health plans to which they apply; some affect both HMOs and PPOs, while others apply only to PPOs. The scope of these laws also may be restricted in other ways. For example, some states exempt group-model and staff-model HMOs. In addition, the Employee Retirement Income Security Act of 1974 restricts the states from applying such laws to self-insured employer plans. Finally, a provision related to restrictive state laws and practices in the federal HMO Act could be interpreted to exclude federally qualified HMOs from state any willing provider laws (and other laws discussed in this chapter), though this issue has not been tested in court.

There is little evidence of the impact of any willing provider legislation. Moreover, differences in the application, implementation, and enforcement of any willing provider laws may complicate efforts to determine their true effect. Studies sponsored by the insurance industry uniformly conclude that any willing provider provisions drive up the cost of health care by increasing administrative and claims costs as well as premiums (Lewin-VHI, Inc. 1995; Wyatt Company 1991; Atkinson & Company 1994; Rogers 1994). AMA, however, has questioned the validity of these studies by claiming that the projected growth in provider participation rates in managed-care networks under these laws was too high. AMA found that, while some states have experienced increases in provider participation rates following the enactment of any willing provider legislation, these have not been as large as those assumed by these studies (Simon 1994).

### **Freedom of Choice Laws**

Freedom of choice provisions allow enrollees to receive covered health care services from any qualified provider they choose, regardless of whether the provider is a member of the managed-care plan's network. Typically, these laws allow enrollees to seek care from out-of-network providers—with no reduction in benefits—as long as the provider agrees to accept the insurer's level of payment for the service. Freedom of choice laws have been passed in about 20 states.

As with any willing provider laws, states have applied these laws to different types of providers. Most are limited to pharmacies; some apply to certain specialists, while others cover most providers. Further, of those that cover all or most classes of providers, only a few apply to all types of managed-care plans.



Most of these laws were passed at the same time as states were enacting any willing provider legislation. As is the case with any willing provider provisions, state legislatures have recently been reluctant to pass freedom of choice legislation. Current legislative efforts have turned away from any willing provider and freedom of choice measures as ways to protect managed-care enrollees. Instead, they are focusing on more specific measures aimed at enhancing the quality of care, such as guaranteeing direct access to specialists and mandating minimum lengths of stay for new mothers and mastectomy patients. With respect to Medicare risk plans, Representative Tom Coburn recently introduced a bill (H.R. 459) that would provide Medicare beneficiaries enrolled in risk contract HMOs the opportunity to obtain health care services outside of the plans' provider networks.

### **Direct Access Laws**

Direct access laws limit the ability of managed-care plans to direct the flow of patients toward specific providers. They ensure enrollees' access to certain specialists (typically obstetrician-gynecologists, dermatologists, ophthalmologists, and psychiatrists) without requiring a referral from a primary care physician. While some of these laws give certain specialists primary care status, others allow patients to self-refer to these physicians for specified services only. The first direct access law was passed in Maryland in 1994. Since then, more than a dozen states have passed such laws, and 20 states require HMOs to allow obstetrician-gynecologists to be classified as primary care physicians.

Even in states without such laws, the managed-care industry has been responding to increased consumer demand for direct access to certain specialists. For example, a 1994 survey of member plans of the Group Health Association of America found that 81 percent of HMOs offer women the choice of an obstetrician-gynecologist as their primary care physician or allow them to self-refer to one (Bernstein et al. 1995).

### **Coverage for Emergency Services**

About a dozen states have passed legislation requiring managed-care plans to pay for emergency services patients receive when they go to an emergency room for what they believe is a serious illness, even when the diagnosis turns out to be minor (e.g., chest pains that are found to have been caused by heartburn). Some states explicitly prohibit HMOs from requiring prior authorization for emergency care and require HMOs to use a prudent layperson definition of emergency (Families USA Foundation 1996). Legislation designed to ensure coverage and treatment of emergency services based on the prudent layperson standard and to prohibit any prior authorization for emergency care was introduced in February of this year by Representative Ben Cardin and Senator Barbara Mikulski (the Access to Emergency Medical Services Act of 1997, H.R. 815/S. 356).

The Commission addressed this issue as it relates to Medicare in its 1996 annual report. It recommended that a prudent layperson's perspective should be considered as one of the factors in

determining when a health plan should pay for initial screening and stabilization in an emergency (PPRC 1996). Currently, Medicare requires health plans to provide or pay for emergency care, but what constitutes an emergency may be misunderstood or disputed by plans and beneficiaries. The definition of emergency is key in resolving these disputes and guiding beneficiaries before they seek such care.

In response to concerns about coverage for emergency services and as a way to specify what constitutes an emergency, AAHP recently issued a statement clarifying its policy in this area. The policy states that “health plans should cover emergency room screening and stabilization as needed for conditions that reasonably appear to constitute an emergency, based on the patient’s presenting symptoms.” AAHP defines emergency conditions as “those that arise suddenly and require immediate treatment to avoid jeopardy to a patient’s life or health” (AAHP 1997a). It is not clear how AAHP’s test of reasonableness differs from the prudent layperson definition used in legislation adopted by several states.

### **Consumer Grievance and Appeals Procedures**

Although all states require HMOs to have grievance procedures, these procedures have been criticized for being unresponsive to enrollee needs for several reasons. First, HMO enrollees are often not adequately informed of their right to file a complaint when services are denied. According to the Commission’s recent survey of Medicare beneficiaries, for example, nearly one-third (31 percent) of all Medicare managed-care enrollees were unaware that they had the right to appeal their plan’s decisions not to provide or pay for a service (Nelson et al. 1996). Second, review of grievances can be a lengthy process, making it especially disadvantageous to enrollees who believe they have been denied medically necessary care (Center for Health Care Rights 1996).

In response to these criticisms, states are beginning to take steps to specify grievance and appeals requirements so that managed-care enrollees will be better informed and have a faster response to their appeals of treatment denials. Until this year, only 9 states had specific grievance procedures in place; currently, more than 30 states have spelled out these requirements in detail (Families USA Foundation 1996).<sup>2</sup>

In a policy statement issued earlier this year, AAHP addressed concerns about consumer grievance and appeals procedures. The policy urges health plans “to explain, in a timely notice to the patient, the basis for a coverage or treatment determination with which the patient disagrees.” This notice should be accompanied by an easily understood description of the patient’s appeal rights and the time frames

---

<sup>2</sup> In addition to state regulations, plans contracting with Medicare must adhere to the Health Care Financing Administration’s procedures for appeals, complaints and grievances. The agency has established specific procedures for Medicare beneficiaries to use in resolving complaints.

for an appeal. The policy further states that “an expedited appeals process should be made available for situations in which the normal time frame could jeopardize a patient’s life or health” (AAHP 1997a).

### **Coverage Mandates: Maternity and Mastectomy Length-of-Stay Provisions**

The practice of sending new mothers home on the day they deliver has become a rallying point for consumer advocates and has been the most frequently considered managed-care consumer protection issue in state legislatures this year. Within the last two years, 30 states have passed legislation governing lengths of hospital stays for deliveries. These laws typically require HMOs to pay for at least a 48-hour hospital stay for mothers and their newborn babies following a normal birth; the requirements are usually longer for cesarean births. In addition, in September 1996 the Congress passed legislation ensuring two-day hospital stays for new mothers. The legislation, which is scheduled to take effect in 1998, requires health plans to pay for at least 48-hour hospital stays for normal deliveries and 96-hour stays for cesarean deliveries.

Mandating coverage for minimum hospital stays following mastectomies is expected to be the next hot issue in state capitals this year. In response, AAHP issued a policy statement urging plans not to require outpatient mastectomy. Rather, AAHP recommends that decisions about a hospital stay following a mastectomy should be made by a woman’s physician in consultation with the patient (AAHP 1996b).

The Health Care Financing Administration (HCFA) in February of this year sent a policy letter to Medicare risk plans banning them from requiring outpatient breast cancer surgeries or setting arbitrary limits on hospital stays for such treatment (HCFA 1997). There is not a lot of evidence, however, that outpatient mastectomies are common. An industry report found that only about 8 percent were performed on an outpatient basis, while another study showed that patients were no more likely to receive an outpatient mastectomy in a managed-care plan than under fee for service (AAHP 1997b).

Currently, there are two different types of bills regarding outpatient mastectomies before the Congress. One type would mandate 48-hour hospital stays. The other does not specify a minimum length of stay, but would leave the decision to the doctor’s and the patient’s discretion, and require the plan to pay for the hospital stay.

### **Physician Gag Clauses**

Consumers have strongly criticized managed-care plans for their use of physician gag clauses. Gag clauses are contractual provisions that may restrict physicians in several ways. They may prevent physicians from fully informing patients about treatment options or about which options are covered by the plan. They may also prohibit referrals to providers for services that are not covered. In addition,



contract clauses may prevent physicians from criticizing the plan, disclosing financial incentives, or discussing how decisions to authorize or deny care are made.

Two different types of clauses have come under scrutiny in recent years. Antidisparagement clauses are designed to prevent disclosure of propriety information and negative publicity about the plan. The second type, provider deselection or termination without cause clauses, permit either party to end the relationship without a reason. Depending on how they are interpreted, both of these could be considered as gag clauses if they compromise communication between patients and physicians, although such provisions do not specifically address issues of medical care.

There is no information on the extent to which physicians contracting with managed-care plans are subject to constraints affecting discussions with patients, primarily because of the confidential nature of these contracts. In addition, there are differences of opinion about the merits of these provisions. The industry considers inclusion of antidisparagement and confidentiality clauses to be a sound business practice. On the other hand, AMA considers such clauses to have a chilling effect on relationships between physicians and patients. Consumer organizations also argue that gag clauses, whether explicit or implicit in provider contracts, stifle physician communication with patients.

A number of states have already moved to restrict gag clauses. Since 1995, 17 states have enacted laws banning these clauses, and similar legislative language is pending in a dozen states. State anti-gag clause provisions generally prohibit managed-care contracts from limiting in any way or from penalizing providers for disclosing to patients information about their medical conditions or treatment options; advocating on behalf of patients; and providing information about health plan policies, including financial incentives or arrangements.

In addition, last year, both the U.S. Senate and House of Representatives considered legislation that would have banned HMOs from including physician gag clauses in their provider contracts. Similar legislation, the Patient Right to Know Act of 1997 (H.R. 586), has been introduced again this year by Representative Greg Ganske and endorsed by the President.

HCFA reiterated its position against physician gag clauses in a November 1996 policy letter which was sent to all health plans serving Medicare beneficiaries. It clarified that contract clauses limiting what physicians may tell Medicare beneficiaries about their treatment options are a violation of federal law. The directive states that physicians providing care to Medicare HMO enrollees "may not be limited in counseling or advising the beneficiary of medically necessary treatment options that may be appropriate for the individual's condition or disease" (HCFA 1996b). In February 1997, HCFA issued a similar directive to all state Medicaid agencies stating that gag clauses are prohibited in Medicaid managed-care plan contracts with providers (Fried 1997).

The industry is also moving to address provider and consumer concerns. Some plans, including Humana and U.S. Healthcare, have announced that they will no longer include such provisions in provider contracts. Moreover, AAHP recently issued guidelines asking plans to inform patients about

(1) how their doctors are paid, including incentive arrangements; (2) how their plan reviews and decides which services will be covered; (3) how their plan determines medical necessity; and (4) how the plan determines whether a proposed treatment is experimental (AAHP 1996a). The guidelines are voluntary, but the association adopted a policy to expel member plans that fail to comply with its quality standards of practice.

### **Provider Due Process Measures**

Provider due process measures require managed-care plans to develop and disclose the criteria and process they use to select providers for their networks. Several types of laws can be considered due process measures, including those related to the appropriateness of criteria used in selection (and deselection) decisions, and those related to provider appeals of network decisions.

More than a dozen states have provider due process protections in some form. Many of these apply to all or most classes of providers, while the rest apply to pharmacies only. The laws also differ with respect to the types of plans affected: some apply only to HMOs, others only to PPOs, and some to both.

Due process laws concerning disclosure may include requirements for plans to provide notice when a network is forming, to disclose provider selection criteria, to provide written public notice for provider contract termination, and to disclose the reasons for terminating a provider's contract. Laws regarding selection criteria may contain requirements that terms and conditions for provider participation in networks be nondiscriminatory and that plans set up preferred provider contracts through a request-for-proposal process, whereby all health providers could submit a bid. Such laws may also require that criteria be fairly applied so that, for example, profiling of physician practice patterns includes appropriate adjustments for case mix. Finally, due process measures may require plans to establish grievance procedures for providers that have been deselected or rejected. More than 10 states have enacted legislation that addresses due process in deselection decisions.

### **Financial Incentives**

HCFA recently issued final rules on physician incentive payment plans used by Medicare and Medicaid HMOs. The rules, which took effect January 1, 1997, implement legislation passed by the Congress as part of the Omnibus Budget Reconciliation Act of 1990. Many health plans use physician financial incentives, along with mechanisms such as profiling, to control utilization of services. Under such arrangements, physicians or physician groups receive incentive payments if they have fewer referrals than expected. Alternatively, when physicians or physician groups have excessive referrals, they do not receive incentive payments and may be liable for referral costs.

HCFA's final rules prohibit the use of physician payments to limit or reduce necessary services to enrollees. In addition, the rules impose disclosure and stop-loss insurance requirements on Medicare and Medicaid HMOs when payments put physicians at substantial financial risk for referral services. According to a guidance document on the final rules, plans with direct contracting and subcontracting arrangements that shift substantial risk must disclose the following information on an annual basis:

- whether referral services are covered by the incentive plan;
- the type of payment arrangement used (i.e., withhold or capitation);
- the percentage of total income at risk for referrals;
- the amount and type of stop-loss coverage;
- the number of enrollees and whether enrollees were pooled to achieve the total;
- for capitated physicians—the previous year's percentage of payment that was for primary care services, specialty referral services, hospital services and other types of providers; and
- a summary of enrollee survey results.

Physician groups that do not transfer substantial financial risk to their own physicians are not required to disclose this information. Intermediaries between physician groups and HMOs (e.g., independent practice associations) are required to report on their incentive arrangements, regardless of the risk transferred (HCFA 1996a). In addition, 11 states have passed laws that restrict the use of financial incentives by managed-care plans to influence the behavior of enrollees and providers (Hellinger 1996).

### **Presidential Commission**

The President recently announced plans to establish an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which will examine both the managed-care and fee-for-service sectors. As part of its assessment of managed care's impact on the health care delivery system, the new commission will develop recommendations on a host of quality and consumer protection issues (Cunningham 1996). Co-chaired by the Secretaries of the Departments of Health and Human Services and Labor, the commission will have representatives from health care professions, providers, insurers, purchasers, consumers, and states, as well as quality and financing experts. The commission is scheduled to submit a preliminary report by September 30, 1997, and a final report 18 months after its first meeting (*Managed Care Week* 1996). It is likely that the commission's formal recommendations will generate further consideration of these issues by the Congress.



## MONITORING EFFECTS OF CONSUMER PROTECTION INITIATIVES

Because the majority of the consumer protection initiatives discussed here are recent developments—some became effective only at the beginning of this year—it is too soon to determine how they have affected managed-care enrollees. Differences in managed-care penetration, as well as the fact that some states have passed comprehensive consumer protection legislation while others have dealt with single issues, further complicate efforts to determine the effects of these initiatives. To evaluate these activities, the Commission will continue to monitor the development, implementation, and enforcement of these measures in the coming year.

## REFERENCES

- American Association of Health Plans, *Health Plans Announce Policies on Appeal Rights and Emergency Care Coverage*, press release (Washington, DC: January 30, 1997a).
- American Association of Health Plans, *Issue Brief: Mastectomy Length of Stay* (Washington, DC: February 1997b).
- American Association of Health Plans, *Health Plans Address Patients' Need for Better Information*, press release (Washington, DC: December 17, 1996a).
- American Association of Health Plans, *Health Plans Should Not Require Outpatient Mastectomy*, press release (Washington, DC: November 14, 1996b).
- Atkinson & Company, *The Cost Impact of "Any Willing Provider" Legislation* (Washington, DC: Group Health Association of America, June 27, 1994).
- Auerbach, Stuart, "Managed Care Backlash: As the Medical Marketplace Changes, Consumers Are Caught in the Middle," *Washington Post, Health Section*, June 25, 1996, p.12.
- Azevedo, David, "Will the States Get Tough with HMOs? Anti-Managed-Care Proposals Pile Up Nationwide," *Medical Economics* 73(16):172-184, August 26, 1996.
- Bernstein, Amy B., Thomas H. Dial, and Mark D. Smith, "Women's Reproductive Health Services in Health Maintenance Organizations," *Western Journal of Medicine* supplement to 163(3):15-18, September 1995.
- Center for Health Care Rights, *Consumer Protections in State HMO Laws, Volume I: Analysis and Recommendations* (Los Angeles: November 1995).

- Cunningham, Robert, "Many Agendas Converging On President's Commission," *Medicine & Health Perspectives*, September 16, 1996, p.1.
- Families USA Foundation, *HMO Consumers at Risk: States to the Rescue* (Washington, DC: July 1996).
- Finkelstein, Ruth, Cathy Hurwit, and Richard Kirsch, *The Managed Care Consumers' Bill of Rights: A Health Policy Guide for Consumer Advocates* (New York: Public Policy and Education Fund of New York and Citizens Fund, October 1995).
- Fried, Bruce, Office of Managed Care, Health Care Financing Administration, Department of Health and Human Services, letter to state Medicaid directors, February 20, 1997.
- Health Care Financing Administration, Department of Health and Human Services, *Office of Managed Care Operational Policy Letter #49*, February 12, 1997.
- Health Care Financing Administration, Department of Health and Human Services, *Office of Managed Care Operational Policy Letter #96.045*, December 3, 1996a.
- Health Care Financing Administration, Department of Health and Human Services, *Office of Managed Care Operational Policy Letter #96.044*, November 25, 1996b.
- Hellinger, Fred J., "The Expanding Scope of State Legislation," *Journal of the American Medical Association* 276(13):1065-1070, October 2, 1996.
- Jensen, Gail A., Michael A. Morrissey, Shannon Gaffney, and Derek K. Liston, "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs* 16(1):125-136, January/February 1997.
- Kostreski, Farah, "States Put Focus on 'Anti-Managed Care' Bills," *Family Practice News*, September 1, 1996, p.70.
- Lewin-VHI, Inc., *The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers, and Families* (Washington, DC: Healthcare Leadership Council, Alliance for Managed Care, and Health Insurance Association of America, June 21, 1995).
- Managed Care Week*, "HMO Consumer Protections Passed by Senate; Clinton Creates Panel," September 9, 1996, p.3.
- Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series, No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).

Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).

Rich, Spencer, "Managed Care, Once an Elixir, Goes Under Legislative Knife: Cost-Cutting Focus Feared Harmful to Patients," *Washington Post*, September 25, 1996, p.A-1.

Rogers, Marc, *Why the United States Cannot Afford Any Willing Provider Legislation* (Washington, DC: AMCRA Foundation, August 10, 1994).

Simon, Carol J., "Review of 'The Cost Impact of Any Willing Provider Legislation'," unpublished paper prepared by the Center for Health Policy Research, American Medical Association (Chicago: July 1994).

Wyatt Company, *Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* (Washington, DC: Health Insurance Association of America, June 7, 1991).





# Constraining Spending in Medicare Fee for Service

The continuing rise in Medicare spending has serious implications for both the program and the federal budget. Currently, the Congressional Budget Office (CBO) projects that spending for the Medicare program will remain at an average annual rate of 8 percent to 9 percent through 2002. Concerns about this ongoing growth in spending have led to proposals for restructuring the Medicare program, relying more on risk plans to restrain costs. One proposal, the Balanced Budget Act of 1995 (H.R. 2491), also included the failsafe budget mechanism, which was specifically designed to constrain spending in Medicare fee for service.

Because of similar high rates of spending growth for physicians' services in the late 1980s, the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislated the Volume Performance Standard (VPS) system to curb spending growth. Although price restraints were used to control spending during the 1970s and the 1980s, spending continued to rise because of increases in the number and mix of services physicians provided. For example, from 1986 to 1992, prices grew about 2 percent per year, while volume and intensity rose about 8 percent (Board of Trustees 1994). Thus, the VPS system was created to help slow spending by setting target rates for spending growth, and then adjusting payment levels depending on whether the targets were met. The target rates of spending growth are called performance standards; adjustments to payment levels based on these standards are called conversion factor updates.

The Commission has long held that a budgeting tool like the VPS system is necessary to constrain spending for physicians'

*This chapter includes:*

- *Experience under the Volume Performance Standard system*
- *A proposed revision, called the sustainable growth rate system*
- *Policy issues for constraining total spending under Medicare fee for service*
- *Recommendations for improving the Volume Performance Standard system*

services, but has also warned that methodological flaws keep the system from working as intended. To correct these flaws, it has made recommendations, which are reiterated here.

*A single volume performance standard and update for all categories of physicians' services should be adopted. The transition to a single conversion factor should occur over a three-year period and should be coordinated with the implementation of resource-based practice expense relative values to prevent large payment reductions for any category of service in a single year.*

## *Recommendations*

*Current policy, which sets the performance standard for physicians' services using the historical trend in volume and intensity growth and the 4 percentage point deduction, should be replaced by a formula linked to the projected growth of real gross domestic product per capita. In addition, estimates of this growth should be increased by 1 or 2 percentage points to allow for advancements in medical capabilities.*

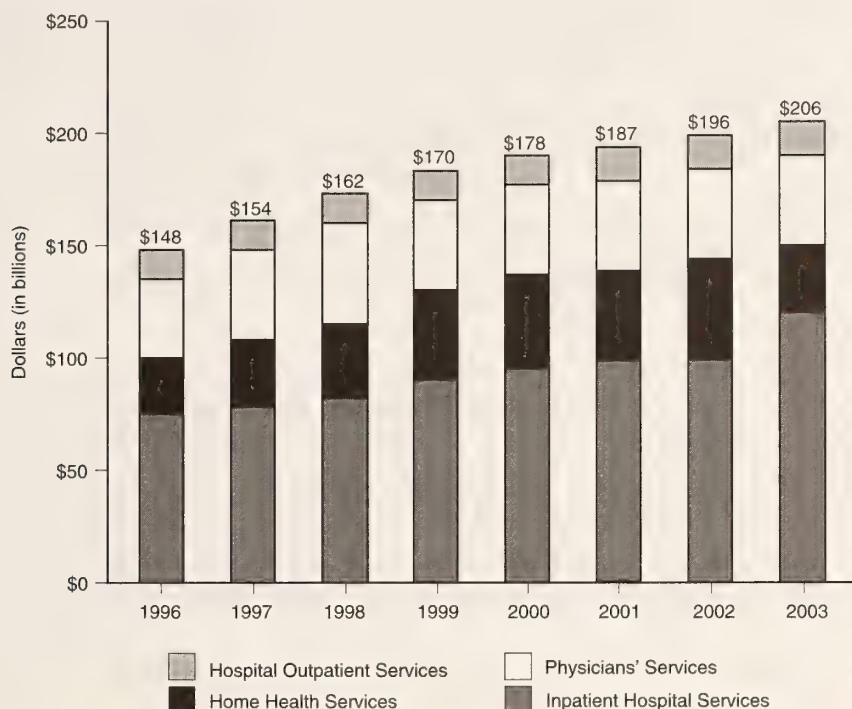
*When setting the annual conversion factor update for physicians' services, symmetric limits should be established to restrict reductions and increases to within 5 percentage points of the Medicare Economic Index.*

Developing a mechanism for constraining spending in the Medicare program as a whole presents additional challenges. While spending growth for physicians' services has slowed, other health care sectors, such as outpatient hospital and home health services, have continued to grow unabated. Projections for spending in these sectors show continued growth, whereas spending for physicians' services will remain constant (Figure 12-1). Currently, only the payment policy for physicians' services incorporates a mechanism that links payment levels to volume and intensity growth. Other sectors, such as inpatient hospital services, curb price through mechanisms like diagnosis-related groups (DRGs), but overall spending growth is not moderated because there are no constraints on the number of admissions. Some sectors, such as outpatient hospital services and home health services, have payment policies that neither effectively restrain prices nor volume. Developing constraints for spending growth in sectors other than physicians' services is difficult, however. Although physicians are predominantly responsible for determining the number and intensity of services delivered in other sectors, they would not be directly affected by reductions in payment levels to providers in other sectors.

This chapter begins by reviewing the experience under the VPS system for physicians' spending, noting some of the difficulties inherent in establishing budget targets. It also discusses other limitations of the VPS system and describes how the sustainable growth rate system would resolve them. Next, the challenges of developing mechanisms to constrain spending for the Medicare program overall are



**Figure 12-1. Projections of Spending by Health Care Sector, 1996-2003 (in billions of dollars)**



SOURCE: Physician Payment Review Commission analysis data from the Congressional Budget Office, January 1997 baseline.

discussed. This section looks at allocation of spending across service sectors, volatility in annual expenditure growth, geographic variation, and the effects of a national expenditure limit system on the VPS system for physicians' services.

## EXPERIENCE UNDER THE VPS SYSTEM

Payment levels under the Medicare Fee Schedule are determined by relative value units (RVUs) and conversion factors that translate relative values into dollar amounts for each service. The VPS system then sets target rates of expenditure growth for a given year. Two years later, actual expenditure growth for that year is compared with the target. Updates to payment levels are then increased or reduced, depending on whether actual expenditure growth fell below or above the target.

The VPS system includes input from several sources to set performance standards and conversion factor updates. The Secretary of Health and Human Services must make recommendations on performance standards and updates to the Congress by April 15 of each year for the upcoming calendar year. The Commission must review and comment on those recommendations, and make its own by May 15. The Congress may adopt these recommendations or set its own updates and performance standards. Otherwise, they are determined by default formulas.

These default formulas are central to the VPS system because they are often used to determine the performance standards and updates. Even when the Congress has chosen to deviate from them, the default formulas have been a starting point for congressional deliberation. In addition, they establish the baseline levels of spending that alternative proposals cannot exceed. When options for Medicare payment to physicians are considered, the spending associated with each is compared with that under the default formulas. Under current budget rules, an option that would raise spending above this baseline cannot be adopted unless the higher spending is offset either by increasing tax revenues or by making spending cuts elsewhere.

## Performance Standards

The first performance standard was set in 1990. Physicians were expected to hold expenditure growth for all services to no more than 9.1 percent (Table 12-1). The 1990 performance standard was compared with actual spending growth in 1990 to determine the update to the conversion factor for 1992. A single performance standard was used to cover all physicians' services for the first year only. Separate performance standards for surgical services and nonsurgical services were used for the next two years. A third category for primary care services was added under OBRA93.<sup>1</sup>

**Table 12-1. Performance Standards, by Category of Service, 1990-1997 (percentage)**

Category of Service	1990	1991	1992	1993	1994	1995	1996	1997
All Services	9.1%	7.3%	10.0%	10.0%	9.3%	7.5%	1.8%	0.3%
Surgical Services	—	3.3	6.5	8.4	—	—	—	—
Nonsurgical Services	—	8.6	11.2	10.8	—	—	—	—
Surgical Services	—	—	—	—	9.1	9.2	-0.5	-3.7
Primary Care Services	—	—	—	—	10.5	13.8	9.3	4.5
Other Nonsurgical Services	—	—	—	—	9.2	4.4	0.6	-0.5

SOURCE: Physician Payment Review Commission compilation of performance standards as reported in the *Federal Register*.

Setting an appropriate performance standard is difficult, yet crucial to the success of the VPS system. Performance standards that are set too high fail to constrain growth of Medicare outlays for physicians' services, whereas those that are set too low can lead to inappropriate payment reductions. Payments that are too low can, in turn, threaten Medicare beneficiaries' access to care.

Performance standards are calculated from the four components of spending growth: inflation, changes in Part B enrollment (excluding those covered by risk contracts), the five-year average for volume and intensity growth, and changes in spending due to changes in law and regulations (Table 12-2). The first step of the calculation takes the product of these four components, which is the rate of spending growth

<sup>1</sup> These categories are defined according to the type of service rather than the specialty of the physician. For example, an office visit provided by a surgeon would fall into the primary care category.

that would be expected to occur if physicians continued to practice as they had previously (Table 12-3). Next, 4 percentage points are subtracted. This legislated deduction is taken to slow the spending growth rate.

**Table 12-2. Components of Expenditure Growth, for 1997 Performance Standards, by Category of Service (percentage)**

Components	Category of Service		
	Surgical	Primary Care	Other Nonsurgical
Inflation	2.0%	2.0%	2.2%
Enrollment Growth	-1.1	-1.1	-1.1
Volume and Intensity Growth*	1.6	4.0	4.0
Changes in Law and Regulation	-2.1	3.4	-1.5

SOURCE: HCFA 1996.

\* Measured as the average annual volume and intensity growth for the prior five years for each category service.

**Table 12-3. Calculation of the 1997 Performance Standards, by Category of Service**

	$\left( \text{Inflation} \times \text{Enrollment} \times \text{Volume} \times \text{Law} \right)$				Performance Standard Factor	Performance Standard
					—	=
Surgical Services	1.020	0.989	1.016	0.979	0.040	0.963
Primary Care Services	1.020	0.989	1.040	1.034	0.040	1.045
Other Nonsurgical Services	1.022	0.989	1.040	0.985	0.040	0.995

SOURCE: HCFA 1996.

NOTE: In percentage terms, the 1997 performance standards are -3.7 percent for surgical services, 4.5 percent for primary care services, and -0.5 percent for other nonsurgical services.

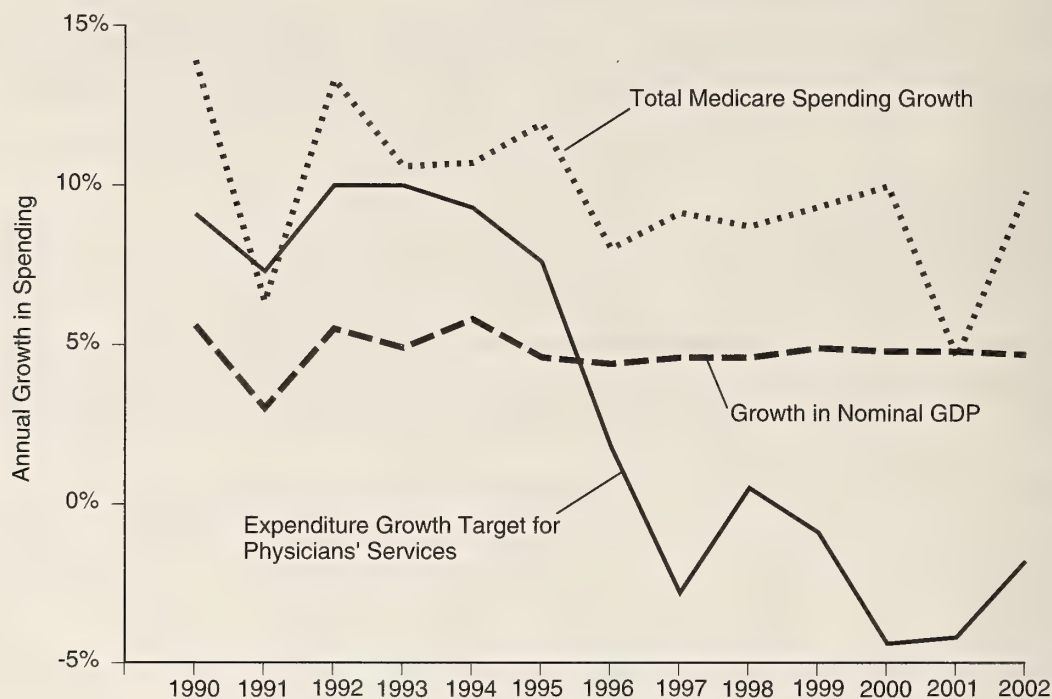
The most difficult aspect of designing an expenditure target system is the choice of an allowance for volume and intensity growth. The current mechanism for setting performance standards uses the five-year historical trends for volume and intensity growth, and then takes a specified deduction from these trends. The deduction is made to account for potential inefficiencies and inappropriate care inherent in the historical trend. This inflexible approach fails to reflect changes in medical practice or in the economy as a whole.

Performance standards under the current system are becoming unrealistically stringent over time, because recent low trends are coupled with much larger legislated deductions. When the first performance standards were calculated, the historical trend was high and only a small deduction was taken. Expectations at the time were that volume and intensity growth would remain high, but that small reductions were feasible. Over time, however, the five-year trend for volume and intensity growth has fallen from about 8 percent in 1992 to about 4 percent in 1996. While the trend has fallen, the legislated deduction has gradually increased from 0.5 percentage points initially to its current 4.0



percentage points. As a result, performance standards, which originally were well above gross domestic product (GDP) growth, are now projected to drop well below (Figure 12-2).

**Figure 12-2. Projected Spending Targets for Physicians' Services Compared to Growth in Nominal GDP and Total Medicare Spending, 1990-2002**



SOURCE: Physician Payment Review Commission analyses of data from the Congressional Budget Office, January 1997 baseline.

The reasons for the drop in volume and intensity growth remain unclear. The decline may be due to changes in the practice of medicine or to the slowing of growth in technologies such as cataract surgery and magnetic resonance imaging. Alternatively, the slowdown may only be transitory.

The Commission has long recommended that the volume and intensity growth reflect the projected growth of real gross domestic product per capita. GDP growth provides a realistic and affordable goal that links the budget targets to what the economy as a whole can afford.<sup>2</sup> In 1990, when the Commission first recommended basing performance standards on growth in GDP, volume and intensity growth exceeded real GDP growth by 4 to 5 percentage points. The Commission thus recommended a gradual five-year transition, so that by 1996 the performance standards would reflect GDP growth plus an allowance of 1 or 2 percentage points.

<sup>2</sup> Projected GDP growth is used because it represents the economy's capacity to grow, but does not reflect business cycles.

## Conversion Factor Updates

The falling trend in volume and intensity growth has led to substantial updates to the conversion factor as well as to declining performance standards (Tables 12-4, 12-5). For example, in 1994 and 1995, the conversion factor updates for surgical services were 10.0 percent and 12.2 percent. The 1994 update of 10 percent occurred because, although the historical trend stayed high (8.1 percent) and the legislated deduction was moderate (1.5 percent), actual volume and intensity growth for surgical services fell to -4.8 percent. Negative volume growth resulting in a large increase was sometimes characterized as paying surgeons more for doing less work. In fact, the VPS was operating as intended by holding spending to its budget trajectory, which incorporated expectations of continued high volume and intensity growth.

**Table 12-4. Conversion Factor Updates, by Category of Service, 1992-1997 (percentage)**

Category of Service	1992	1993	1994	1995	1996	1997
All Services	1.9%	-	-	-	-	-
Surgical Services	-	3.1%	-	-	-	-
Nonsurgical Services	-	0.8	-	-	-	-
Surgical Services	-	-	10.0%	12.2%	3.8%	1.9%
Primary Care Services	-	-	7.9	7.9	-2.3	2.5
Other Nonsurgical Services	-	-	5.3	5.2	0.4	-0.8

SOURCE: Physician Payment Review Commission compilation of conversion factor updates as reported in the *Federal Register*.

**Table 12-5. Conversion Factors, by Category of Service, 1992-1997 (dollars)**

Category of Service	1992	1993	1994	1995	1996	1997
All Services	\$31.00	-	-	-	-	-
Surgical Services	-	\$31.96	-	-	-	-
Nonsurgical Services	-	31.25	-	-	-	-
Surgical Services	-	-	\$35.16	\$39.45	\$40.80*	\$40.96*
Primary Care Services	-	-	33.72	36.38	35.42*	\$35.77*
Other Nonsurgical Services	-	-	32.90	34.62	34.63*	\$33.85*

SOURCE: Physician Payment Review Commission compilation of conversion factors as reported in the *Federal Register*.

\* These conversion factors include an additional budget-neutrality adjustment that offsets increases in spending from changes to the relative value units and other payment policy changes.

The VPS system has led to other problems as well. Different performance standards and updates for each of the three categories of services have distorted relative payments, so that an RVU in one category is no longer paid the same amount as an RVU in another category. In 1997, the conversion factor for surgical services is \$40.96, compared with \$35.77 for primary care services. Although the Medicare Fee Schedule was designed to encourage the provision of more primary care services by increasing relative payments for these services, the VPS system was designed to reduce payments if more services are provided.

Eliminating the distortion in payment will require adopting a single conversion factor for all services, and using a single performance standard and update thereafter.<sup>3</sup> Implementing a single conversion factor at the same time as resource-based practice expense relative values could lead to substantial changes in payment for some specialties, however. A transition to a single conversion factor should be provided to prevent any category from experiencing a large one-time increase or decrease (PPRC 1996).

## **IMPROVING THE CURRENT VPS SYSTEM**

Recent proposals by the Congress and the Administration would replace the current VPS system with the sustainable growth rate system, which incorporates most of the Commission's past recommendations for improving the VPS system. The proposed approach would use a new methodology that adopts a single conversion factor and uses projected growth of real GDP per capita. It would also eliminate the two-year delay and adjust the conversion factor annually to ensure that total actual spending accrued since a base year is held to target spending levels.

Performance standards under the current system would be replaced by the sustainable growth rate under the proposed approach. The sustainable growth rate would reflect inflation, changes in enrollment, and changes in spending due to changes in law and regulations. Rather than relying on historical trends of volume and intensity growth, however, it would use growth in real GDP per capita. Proposals by the Congress would provide an additional 2 percentage points of growth to allow for advancements in medical capabilities, whereas the Administration's proposal would provide an allowance of 1 percentage point.

The sustainable growth rate system is designed to recoup excess spending or return shortfalls within one year. This can lead to substantial fluctuations in the conversion factor from year to year, because of the inherent volatility of annual spending growth. Limits on the size of annual updates are therefore critical for preventing undue changes in payment levels. Any excess spending or surplus beyond these limits is recovered in subsequent years. While the system proposed by the Congress would constrain

---

<sup>3</sup> Because payments for anesthesia services reflect base and time units, these services have their own conversion factor. For 1997, the conversion factor for anesthesia services is \$16.68. Anesthesia services, however, are included in surgical services for the purposes of determining performance standards and conversion factor updates.



the size of the annual increases to 103 percent of the Medicare Economic Index (MEI) and would hold reductions to 93 percent of the MEI, the Administration's proposal would allow reductions to 91.75 percent of the MEI. The Commission favors a more narrow and symmetric range of 105 percent and 95 percent of the MEI, respectively.

Although the sustainable growth rate system would establish a more reasonable target—and hold to it better than the current VPS system—substantial changes in the medical marketplace could make the target based on GDP growth unrealistic as well. If increased efficiencies in the delivery of care markedly slow volume and intensity growth or if other payers substantially lower their payment levels, Medicare may want to reduce its sustainable growth rate and conversion factor accordingly. Alternatively, if new treatments and diseases or risk selection result in higher volume and intensity growth, it may be appropriate to raise the sustainable growth rate.

## **POLICY ISSUES FOR CONSTRAINING SPENDING IN MEDICARE FEE FOR SERVICE**

There are two general strategies for constraining fee-for-service spending: expenditure targets and expenditure limits. An expenditure target system establishes a level of spending, and then adjusts payments up or down so that, on average over time, spending matches the planned budget trajectory. The VPS system for physicians' services is an example of an expenditure target policy. Total Medicare spending for physicians in fee for service is kept fairly predictable because—regardless of the number and intensity of services provided—payments are adjusted so that spending for physicians' services is held to the level of the established targets.

Alternatively, an expenditure limit system sets a ceiling for spending and only adjusts payments downward as needed when spending exceeds the limit. If spending falls below the limit, payments are not adjusted and the shortfall is garnered as additional savings to the Medicare program. The failsafe budget mechanism is an example of an expenditure limit system.

Difficulties arise when designing expenditure target or expenditure limit systems to constrain spending. Appropriate levels of spending for the Medicare program must first be established. As demonstrated by experience under the VPS system, relying on historical trends or projections based on trends is problematic, because these trends do not reflect changes in technology, practice patterns, or other changes in the medical marketplace. Linking spending growth to growth in GDP provides a preferable alternative, but may not reflect the nuances of the medical marketplace.

Additional complexities arise when designing a mechanism for constraining overall fee-for-service spending in the Medicare program. First, decisions must be made about how to allocate total Medicare fee-for-service spending across service sectors. That has important implications for the efficiency of health care delivery and the substitution of services across the sectors. In addition, the system's design should allow for fluctuation in year-to-year spending. Annual variation in overall spending can be

substantial and can be magnified within each of the sectors. Another complication is that a national expenditure limit can negatively affect some geographic areas relative to others.

### **Allocation of Spending across Sectors**

A policy to constrain Medicare spending must first determine how to allocate any reductions across categories of services. That requires defining suitable categories and establishing an initial allocation of spending for each category. In addition, the policy must provide a method for changing the allocations over time as appropriate.

The choice of categories and the method of allocating across these categories has important implications for how the policy will affect health care delivery. Changes in payment levels across service sectors can alter incentives related to where and how care is provided. For example, a policy that would have locked in shares of spending by service sector in the 1980s could have hindered innovations that moved many services from hospital inpatient to ambulatory care settings.

A natural categorization of service sectors follows Medicare's policies for paying providers and institutions. Part A services can be divided into four sectors: inpatient hospital, skilled nursing facility, home health, and hospice. Part B services include physicians' services, outpatient hospital services, and other medical services like durable medical equipment.

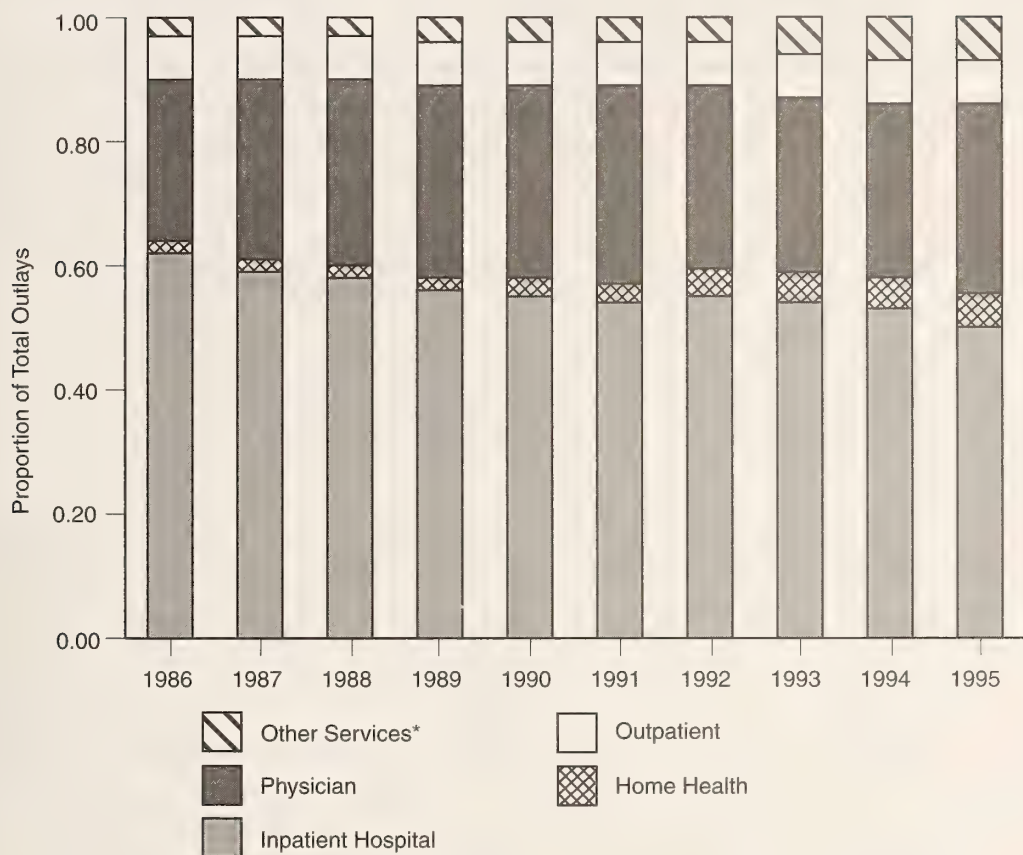
One strategy for allocating spending across service sectors would be to establish baseline levels of spending using historical trends. The amount of allowed spending for a given year could then be apportioned across the sectors using these baseline levels. Currently, the inpatient hospital sector accounts for the largest share of Medicare spending (Figure 12-3). In 1993, inpatient hospital services represented 52 percent of total Medicare outlays and physicians' services, 24 percent.

Determining how these allocations should change over time is more difficult. It would require forecasting appropriate and efficient substitution of services within each service sector, that in turn would require predicting new trends resulting from changes in medical technology, procedures, and drugs.

One approach is to use historical trends to predict future changes. From 1983 to 1993, spending for inpatient hospital services declined from 65 percent to 52 percent of total Medicare outlays. Based on this trend, a continued decline might be expected. But the spending trend for physicians' services has been less predictable, rising from 23 percent in 1983 to 28 percent in 1988 and 1989, before falling to 24 percent in 1993. The 10-year pattern suggests that the share of physicians' spending might remain constant, whereas the most recent 5-year pattern suggests a slow descent.

Using historical trends to project future spending, can thus, be problematic. Because of year-to-year variation, it is hard to determine whether a few years of slowing expenditure growth signal the beginning of a continuing downward trend or whether expenditure growth will return to previous historical levels. As a result, some projections may assume that the slowdown will be reversed, and hence anticipate a return to historical averages. Other estimates may project a continuing downward trend.

**Figure 12-3. Shares of Total Medicare Outlays, by Sector, 1986-1996**



SOURCE: Committee on Ways and Means, U.S. House of Representatives, 1994 Green Book.

\* Other services include hospice and skilled nursing facility services.

NOTE: Proportion of total outlays for 1994 and 1995 are projections.

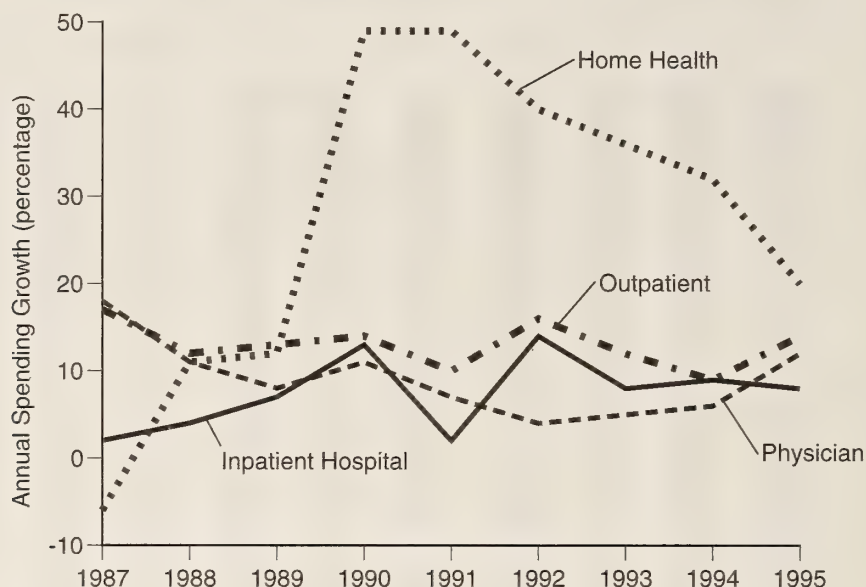
### Managing Year-to-Year Volatility

Because annual expenditure growth rates for Medicare spending are unpredictable and highly variable, it is difficult to set policies to constrain spending. From 1983 to 1993, for example, annual growth rates for Medicare ranged from a low of 4.3 percent to a high of 11.8 percent. From 1989 to 1991, growth rates fell from 11.8 percent to 4.3 percent and then rose to 11.0 percent. Such high variation makes it hard to design a policy that sets predictable rates of spending without imposing payment levels that fluctuate widely from year to year.

The volatility in annual expenditure growth rates is magnified within each of the service sectors. Inpatient hospital services—the largest sector—had annual growth rates ranging from 2 percent to 15 percent over this time period (Figure 12-4). Year-to-year fluctuations were even greater in the smaller sectors like skilled nursing facilities, home health, and hospice. How much of these fluctuations were caused by Medicare payment policy and how much by changes in utilization patterns is difficult to determine.



**Figure 12-4. Annual Spending Growth for Various Sectors, 1987-1995 (percentage)**



SOURCE: Committee on Ways and Means, U.S. House of Representatives, 1994 Green Book.

NOTE: Proportion of total outlays for 1994 and 1995 are projections.

The challenge is to develop policies that achieve the desired rate of growth without producing large annual fluctuations in payment levels. Under a system of expenditure targets and limits, the spending for the Medicare program would become more predictable, because the system would adjust payment levels to hold spending to predetermined levels. The drawback is that the payment levels would become unpredictable for providers because payment levels would vary each year, reflecting annual fluctuations in volume and intensity growth.

One approach for mitigating variation would be to lower payments in sectors with excess spending if total spending across all sectors exceeded the fee-for-service limit. That would allow underspending in some sectors to offset excess spending in others. If no excess spending occurred, the surplus would accrue to the Medicare program as savings.

Another approach would be to establish separate expenditure limits for each sector, and restrict the size of any year's reduction in payment level. Excess spending that fell outside the limits could be accounted for in subsequent years, as it is in the sustainable growth rate system for physicians' services. With this approach, because each sector would be held to its own spending limits, establishing the proper allocation for each one would be especially important. Otherwise, appropriate substitution of services to other health service sectors such as outpatient settings might be stifled. In addition, the expenditure limit system for a particular sector should be consistent with that sector's payment mechanism.

## Differences across Geographic Areas

Currently, per capita spending rates across geographic regions vary substantially. Both fee-for-service and capitation payment levels are about \$1,000 less in rural than in urban areas, for example (Table 12-6). Some of this difference appropriately reflects disparities in the cost of living and health status, while some is related to variation in practice style and efficiency.

**Table 12-6. Estimated Annual per Capita Spending in Medicare Fee for Service and Managed Care by Geographic Area (dollars)**

Geographic Area	Average Annual Fee-for-Service Per Capita Spending	Average Estimated Capitation Payment
Census Region		
New England	\$4,681	\$4,654
Middle Atlantic	4,615	5,034
East North Central	3,896	4,184
West North Central	3,336	3,716
South Atlantic	4,226	4,060
East South Central	3,960	3,884
West South Central	4,266	4,125
Mountain	4,093	3,908
Pacific	4,205	4,841
Urban/Rural		
Urban	4,378	4,571
Rural	3,466	3,481

**SOURCE:** Physician Payment Review Commission analysis of the Medicare Current Beneficiary Survey, 1994.

**NOTE:** Average capitation payments are calculated for survey respondents in Medicare fee for service based on what their 1994 capitation payment would have been if they were enrolled in Medicare managed care.

Constraining spending using national expenditure limits and targets could potentially heighten these differences. Payment reductions could be triggered by the inefficient practices in some areas, but would also apply to areas with efficient practices. Furthermore, geographic areas with more medical resources would have a greater opportunity to offset reductions in payment by increasing the number and mix of services provided.

In addition, some proposals for restructuring Medicare aim to uncouple capitation payments from fee-for-service spending yet maintain comparable per capita spending levels between Medicare managed care and fee for service. A feature in these proposals incorporates floors for payments that set a minimum capitation payment for rural areas. Combined with a policy of expenditure limits or targets, this policy could lead to substantial differences in per capita spending in these areas. While capitation

payments would never fall below a specified amount, fee-for-service payments might be reduced because of overutilization in other geographic areas.

### **Implications for the VPS System**

Some of the proposals for restructuring the Medicare program would replace the current VPS system with the sustainable growth rate system within an overall expenditure limit system. Conflicts may arise, however, when mechanisms within the two systems work at cross-purposes. The sustainable growth rate system constrains spending within the physician service sector and accounts for spending within that sector over time. In other words, the system creates a separate "bank account" for physicians' services so that surpluses and shortages in one year can be credited or debited from spending in succeeding years.

A potential conflict would occur if this system were combined with an overall system of expenditure limits that used surpluses in one sector to offset shortages in another. Under the sustainable growth rate system alone, if spending for physicians' services were less than expected, the garnered surplus would be applied to future spending for these services. Under a combined system, by contrast, it would be applied to offset spending in other sectors.

A potential alternative would be to adopt the sustainable growth rate system but to have it operate independent of the overall expenditure limit system. That would avoid conflicts in the methodologies of the two systems, yet would continue to curb spending across sectors.

Another alternative would set spending constraints for the system as a whole, and no longer have a separate system of controls for physicians' spending. As long as the current trend in volume and intensity growth holds, increases in physicians' spending should not encroach on spending in other sectors. This would make approaches across sectors comparable and would avoid having the overall expenditure limit or expenditure target conflict with the one for physicians' services.

### **REFERENCES**

- Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *Report to Congress: The 1994 Annual Report of the Board of Trustees of the Federal Supplementary Medicare Insurance Trust Fund*, Committee Print 103-229 (Washington, DC: Committee on Ways and Means, U.S. House of Representatives, April 1994).
- Committee on Ways and Means, U.S. House of Representatives, *1994 Green Book: Overview of Entitlement Programs*, Committee Print 103-27 (Washington, DC: July 15, 1994).
- Health Care Financing Administration, Department of Health and Human Services, "Physician Fee Schedule Update for the Calendar Year 1997 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1997," *Federal Register* 61(227):59717-59724, November 22, 1996.
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).



# Medicare Fee Schedule Payment Issues

With the completion of the transition in 1996, the Medicare Fee Schedule became the sole basis for Medicare payments to physicians. Nonetheless, important refinements to the fee schedule are still taking place, improving the accuracy with which it measures the relative resources required to provide each service. The work component of the fee schedule was comprehensively reviewed in 1996, and resource-based practice expense relative values are being developed for 1998. The Health Care Financing Administration (HCFA) has also revised the payment areas used for the fee schedule's geographic adjustment factors (GAFs) in 1997.

The most controversial refinement continues to be the development of resource-based practice expense relative values. Some are concerned that HCFA has not gathered sufficient data to permit the development of accurate values by 1998, and are urging a one-year delay in implementation. The Physician Payment Review Commission disagrees. The transformation of practice expense relative values from charge-based to resource-based is long overdue. HCFA has sufficient information to develop initial values by 1998, and no new data are expected to be available within the year that could assist in the process. The Commission reiterates its previous recommendation that the Congress should require a multiyear transition to the new values, and that HCFA should create a refinement process to correct any inaccuracies in the initial values. If implementation of resource-based values is delayed—contrary to the Commission's position—the length of the phase-in should be shortened by the period of the delay.

*This chapter includes:*

- *Effects of policy changes on 1996 fee schedule payments*
- *Recommendations for implementing resource-based practice expense and malpractice expense relative values*
- *Results of the five-year review of work relative values*
- *Changes in Medicare payment areas*

## Recommendations

*Resource-based practice expense relative values should be implemented in 1998 as scheduled. The Congress should revise current law so that the new values are phased in over three years. The Health Care Financing Administration should develop a process to refine the initial values. The refinement process should include input from interested parties, as occurred when physician work values were first introduced. The process should be announced when proposed values are released for public comment.*

*The Congress should revise current law so that the malpractice expense component of the Medicare Fee Schedule will be resource based. The Health Care Financing Administration should be directed to collect data on risk groups and relative insurance premiums across insurers that can be used to develop new malpractice expense relative values.*

This chapter analyzes this year's changes to the fee schedule and those that are anticipated shortly. It begins by describing the effects of payment policy changes on the actual pattern of payments to physicians in 1996. The next section reviews progress in developing new resource-based practice expense values. In the third section, the five-year review process is described and the results are highlighted. The final section analyzes the changes HCFA has made to the fee schedule payment areas and geographic adjustment factors.

### EFFECTS OF POLICY CHANGES ON 1996 FEE SCHEDULE PAYMENTS

In 1996, Medicare's physician payment rates decreased, on average, about 2 percent from 1995 levels (Table 13-1).<sup>1</sup> Payment rates were influenced the most by the low conversion factor updates for 1996 and the completion of the transition to Medicare Fee Schedule payments. Changes in relative value units (RVUs) had a lesser effect, and changes in the geographic adjustment factors had a negligible effect.<sup>2</sup>

In accordance with the current Volume Performance Standard system, conversion factor updates vary by type of service. For 1996, the updates were -2.3 percent for primary care services, 3.8 percent for surgical services, and 0.4 percent for other services.<sup>3</sup> The average conversion factor update for all services, weighted by total payments in each service category, was 0.6 percent.

---

<sup>1</sup> To measure the effects of policy changes on payment rates, claims data from the first six months of 1995 were compared with claims data from the first six months of 1996. The data were from a 5 percent sample of beneficiaries.

<sup>2</sup> The sum of these four influences—conversion factor updates, the transition to the fee schedule, RVU changes, and GAF changes—is the total change in payment rates.

<sup>3</sup> The conversion factor updates for 1997 were 2.5 percent for primary care services, 1.9 percent for surgical services, and -0.8 percent for other nonsurgical services (see Chapter 12 for a more detailed discussion of the Volume Performance Standard system).

**Table 13-1. Effect of Policy Changes on Fee Schedule Payments, 1995-1996**

Type of Service, Location, and Specialty	Total Change in Medicare Payment per Service	Percentage Change Due to			
		Conversion Factor Updates	Relative Value Unit Changes	Geographic Adjustment Factor Changes	Transition to Fee Schedule
All Services	-2.1%	0.6%	0.3%	0.1%	-3.1%
Type of Service					
Evaluation and management					
Primary care	0.6	-2.3	1.8	0.0	1.1
Other	2.0	0.4	0.1	0.0	1.5
Surgical	-4.9	3.8	-1.6	0.0	-7.1
Other Nonsurgical	-3.4	0.4	1.0	0.1	-4.9
Location					
Metropolitan areas					
Greater than 1 million	-2.0	0.6	0.5	0.2	-3.3
Less than 1 million	-2.2	0.7	0.2	0.0	-3.1
Rural counties					
Greater than 25,000	-1.9	0.6	0.1	-0.3	-2.3
Less than 25,000	-0.5	0.0	0.2	-0.6	-0.1
Specialty					
Primary care					
Family/general practice	0.2	-1.2	0.3	-0.1	1.2
Internal medicine	-0.4	-0.8	0.5	0.1	-0.2
Other medical					
Cardiology	-6.5	0.1	-1.0	0.0	-5.6
Gastroenterology	-4.1	0.2	0.0	0.1	-4.4
Other medical	2.7	-0.1	3.9	0.1	-1.2
Surgical					
Dermatology	-0.2	2.3	0.0	0.1	-2.6
General surgery	-1.5	2.5	-0.1	0.0	-3.9
Ophthalmology	-9.6	2.3	-3.4	0.0	-8.5
Orthopedic surgery	-2.6	2.5	-0.5	0.0	-4.6
Thoracic surgery	-2.6	3.3	-0.2	0.0	-5.7
Urology	0.7	2.0	0.4	0.0	-1.7
Other surgical	-2.4	1.9	-0.6	0.0	-3.7
Other					
Pathology	-6.2	0.4	-0.1	0.1	-6.6
Radiology	-3.8	0.4	0.0	0.0	-4.2
Other	-0.2	0.6	2.9	0.0	-3.7

SOURCE: Physician Payment Review Commission analysis of 1995-1996 claims, 5 percent sample of beneficiaries.

NOTE: Changes due to the transition to fee-schedule based payments are calculated as the difference between total payment changes and the sum of changes attributable to relative value changes, geographic adjustment factor changes, and conversion factor updates.



The variation in conversion factor updates led to differences in average updates among specialties and geographic areas, reflecting differences in the mix of services provided. The average update ranged from -1.2 percent for family/general practice to 3.3 percent for thoracic surgery. For metropolitan areas and rural counties with populations of more than 25,000, the average updates were near the national average, 0.6 percent to 0.7 percent. For rural counties with populations less than 25,000, the average conversion factor was essentially unchanged from 1995 to 1996 because of the greater share of primary care services provided in those counties.

Relative value unit changes implemented in 1996 included reductions in practice expense RVUs for some procedures, as required by the Omnibus Budget Reconciliation Act of 1993 (OBRA93), and refinement of work RVUs for some procedures.<sup>4</sup> The changes ranged, on average, from -1.6 percent for surgical services to 1.8 percent for primary care.

GAF changes reflected the use of more current price data and technical improvements in calculating the payment adjustments. The GAF changes, which were intended to be budget neutral, averaged 0.1 percent.

Effects of the final transition to the fee schedule varied by type of service. Payment for primary care evaluation and management (EM) services increased 1.1 percent, while payment for other EM services rose 1.5 percent. The transition caused payment reductions for all other types of services, including -7.1 percent for surgical services and -4.9 percent for nonsurgical services.<sup>5</sup>

## **RESOURCE-BASED PRACTICE EXPENSE AND MALPRACTICE EXPENSE RELATIVE VALUES**

Ever since the Omnibus Budget Reconciliation Act of 1989 mandated implementation of a resource-based fee schedule for Medicare, the Commission has considered the use of charge-based practice expense and malpractice expense relative values as temporary. Charge-based values are inconsistent with the goals and intent of a resource-based fee schedule, but methods to develop resource-based values for these fee schedule components were not available in 1989. After several years of developing and testing different approaches, the Commission concluded that it was feasible to develop resource based values for both practice expense and malpractice expense (PPRC 1990; PPRC 1991; PPRC 1992a; PPRC 1992b; PPRC 1993). Although the Congress has not acted on the Commission's

---

<sup>4</sup> An example of an RVU refinement is the increase in work RVUs for excision of gum lesion from 1.26 to 3.04. An example of an OBRA93 practice expense reduction is the decrease in practice expense RVUs for cataract lens replacement from 13.93 to 12.66.

<sup>5</sup> The magnitude of these effects reflects in part the transition rules under OBRA89. In 1992, payment rates were not permitted to change by more than 15 percent from their 1991 levels. From 1993 through 1995, payments subject to the transition were a blend of historical and fee schedule rates. During those three years, the percentage of the payment based on the fee schedule increased gradually from 25 percent to 50 percent. The percentage jumped abruptly to 100 percent in 1996, when payments were based entirely on the fee schedule. The OBRA93 practice expense RVU reductions also magnified the transition effects by increasing the difference between historical and fee schedule payment rates for some services.

recommendation to institute resource-based malpractice expense relative values, in 1994 it mandated that the Secretary of Health and Human Services develop new resource-based practice expense relative values by 1998. That legislation required the Secretary to use the Commission's approach, which divides practice expense into direct and indirect costs.

HCFA has undertaken this task with the help of three outside research contracts. It is developing values that will be issued in a proposed rule in late spring of this year. After analyzing public comments, final values will be published in the fall for use in 1998.

The rest of this section reviews the progress in developing resource-based practice expense relative values, emphasizing the findings from the HCFA-sponsored projects. It begins by reviewing the Commission's previous analysis and recommendations on how to derive the new values. It then describes HCFA-sponsored studies and compares them with the Commission's work. The last section discusses the concerns of those who advocate a delay in implementing the new values.

### **Commission's Approach to Developing Resource-Based Practice Expense Relative Values**

The Commission's analyses and recommendations have focused on methods to develop accurate resource-based practice expense relative values and on whether the new values should be adopted in one step or phased in. The Commission recommended using an approach that treats direct and indirect costs separately, and implementing the new values over a transition period. The Congress adopted the former recommendation, but not the latter.

**Direct and Indirect Costs.** The goal in developing new practice expense relative values is for each value to reflect as accurately as possible the relative resources required to provide each service. The Commission recommended a commonly used accounting approach that would split the pool of practice expense relative values into two parts. One would be for direct costs like clinical personnel time and medical supplies required to provide a specific service to an individual patient. The other would be for indirect costs like rent, utilities, and business support costs associated with maintaining a physician practice, regardless of the particular services provided. Under this approach, relative values for direct costs would be assigned to individual services based on information about the actual resources used to provide each service. Indirect costs would be allocated on some basis that would ensure that the mix of services each physician provides would include, as closely as possible, the appropriate amount of relative values for indirect costs. Several valid methods are available to do this. To develop relative values under the Commission's approach, then, data must be obtained on the direct costs of providing specific services, and a method must be chosen to allocate indirect costs.

In 1991, the Commission conducted a pilot study to test the feasibility of this approach (PPRC 1991; PPRC 1992a; PPRC 1992b). Direct cost data were collected from three large multispecialty clinics. Indirect costs were allocated based on physician work plus direct costs. Although the Commission would have preferred basing indirect cost values on physician time per service, these data were not available at the time. Because of its restricted scope, the Commission's study included only a limited

number of office-based services. The study's findings led the Commission to conclude that resource-based practice expense values could be developed by collecting direct cost data at the service level and choosing an acceptable method to allocate indirect costs.

In some nonoffice settings, the institution supplies the resources needed to provide the service (direct costs such as equipment and an assistant) and is paid separately by Medicare. To avoid paying twice for these direct costs, current HCFA policy includes a fixed reduction of 50 percent in the practice expense relative value for a group of about 650 services when they are performed in settings other than the office. The 50 percent figure is a rough approximation that does not vary by the service, even though the direct costs do vary. The Commission subtracts the direct cost portion of the practice expense relative value from the physician's payment in these circumstances. That tailors the reductions more precisely to the actual differences in resource costs among different sites of service.

The Congress adopted the Commission's approach when it passed technical amendments to the Social Security Act in 1994. The legislation called for implementation of resource-based relative values in 1998 that reflect both the direct and indirect costs of each service in the fee schedule. It also provided for payments that differed by service site, as the Commission proposed.

**Transition and Refinement.** Although the 1994 legislation did not adopt a phased implementation, the Commission has renewed its call for a multiyear transition to the new values (PPRC 1996). The Commission's analyses suggest that when resource-based practice expense values are introduced into the fee schedule, the practice expense relative values for about 36 percent of services will increase more than 25 percent; about 39 percent will decrease more than 24 percent (Table 13-2). For a number of

**Table 13-2. Distribution of Changes in Relative Value Units under Resource-Based Practice Expense Estimates (percentage)**

Change in Relative Value Units*	Percent of Services	
	Practice Expense Relative Value Units	Total Relative Value Units
Reductions		
More than 25 percent	39.3%	27.7%
16 percent to 25 percent	13.5	7.1
6 percent to 15 percent	3.2	18.3
Change Within 5 Percent	5.7	9.4
Increases		
5 percent to 14 percent	1.0	6.0
15 percent to 24 percent	1.4	22.7
More than 24 percent	35.9	8.9
Total	100.0	100.0

SOURCE: PPRC 1992b.

\* Reductions and increases reflect a comparison of Physician Payment Review Commission estimates of relative value units with 1992 relative value units.



specialties this may produce changes exceeding 30 percent in aggregate practice expense relative value units (Table 13-3). Changes in total relative values will be somewhat more modest, because practice expense constitutes only 41 percent of an average service's total relative value. Similarly large changes in payment were projected when the fee schedule was first implemented. A four-year transition period was provided to avoid disruptions in physicians' practices. Consistent with this, the Commission recommends phasing in the change in practice expense relative values over three years.<sup>6</sup>

**Table 13-3. Ratio of Estimates of Resource-Based Practice Expense to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty**

Type of Service, Specialty	Ratio of Resource-Based to Fee Schedule Value for:	
	Practice Expense Relative Value Units	Total Relative Value Units
Type of Service		
Evaluation and management	1.33	1.12
Surgical global	0.44	0.71
Diagnostic procedure	0.72	0.81
Laboratory	0.73	0.85
Technical procedure	1.00	1.00
Specialty		
Primary care		
Family/general practice	1.33	1.13
Internal medicine	1.13	1.05
Other medical		
Cardiology	0.78	0.90
Gastroenterology	0.68	0.85
Surgical		
General surgery	0.86	0.94
Ophthalmology	0.77	0.88
Orthopedic surgery	0.73	0.87
Thoracic surgery	0.56	0.79

SOURCE: PPRC 1992b.

NOTE: Estimates are based on 1991 service volumes and 1992 relative value units (RVUs).

The Commission is also reiterating its earlier recommendation that HCFA implement a process for refining the new practice expense relative values. By including all interested parties in this process, errors would be corrected and the new values would be more accepted. Given the concern that many

<sup>6</sup> The Commission has not proposed a particular transition approach. A simple method is to move the value for each service one-third of the way to the new value each year. This strategy, however, requires services with even small changes to be phased in. An alternative, similar to the one employed for several other aspects of the fee schedule, is to use such a phase-in for services with changes larger than some threshold. The thresholds should be set to avoid the asymmetry in gains and losses that characterized the transition to the fee schedule (PPRC 1992a).

physician groups and others have about the process being used to develop these values, a carefully designed and implemented refinement process is particularly important. The inclusive process used earlier to refine the work relative values is a helpful example on which HCFA can build. The agency should clarify as soon as possible how refinement of values will proceed, so that interested groups can begin now to collect and analyze data to inform this process.

**Behavioral Offset.** HCFA should clearly state the assumptions underlying the proposed values. One of these is the behavioral (or volume) offset, which attempts to anticipate how physicians will react to changes in payment. Similar questions arose when the fee schedule was created in 1992. Then, HCFA actuaries assumed that physicians whose payments fell would provide more services to offset half of their lost revenues, while those whose payments rose would not provide fewer services. Based on these assumptions, the initial conversion factor was reduced by 6.5 percent from what it would have been if no behavioral offset had been assumed.

The Commission responded to this issue in two ways. First, it recommended that HCFA assume any volume response would be symmetrical: While physicians for whom payments dropped might increase the number and mix of services they furnished to maintain their revenues, it is also likely that those experiencing payment gains might reduce volumes somewhat. Second, the Commission conducted empirical analyses to determine how physicians actually responded to the fee changes when the Medicare Fee Schedule was implemented. These analyses suggested that volume rose only by 1 percent to 2 percent. The 6.5 percent reduction in the conversion factor was too large.

As HCFA prepares its proposed regulation on new practice expense relative values, it must decide whether there will be a behavioral offset and, if so, its size. In making this decision, the agency should consider the Commission's analyses of what actually occurred in 1992, as well as changes in the practice environment since then. For example, the growth of managed care may affect the ability of physicians to increase service volume in response to payment reductions.

### **HCFA's Progress in Developing New Values**

To help develop the data and methodology needed to establish resource-based practice expense relative values, HCFA let three outside contracts (Table 13-4). The largest, with Abt Associates, Inc., included a variety of activities to collect information about the direct and indirect costs associated with providing individual services. The other two contracts, with Harvard University researchers Daniel Dunn and Eric Latimer and with Health Economics Research, Inc. (HER), tested different methods of allocating indirect costs using currently available data.<sup>7</sup>

---

<sup>7</sup> Dunn is now at Cambridge Health Economics Group.

**Table 13-4. Summary of Four Research Studies Relating to Practice Expense**

Organization	Goal of Study	Method for Direct Cost	Method for Indirect Cost
Physician Payment Review Commission	Identify methods for direct and indirect costs; test feasibility of direct cost data collection	Service-level data collected from physician practices	Based on physician work plus direct costs*
Harvard	Use existing data to develop relative values; focus is on indirect cost method	Applied revenue shares to current charge-based practice expense values	Based on physician time
Health Economics Research	Use existing data to develop relative values; focus is on indirect cost method	Applied revenue shares to current physician work values	Based on physician work
Abt Associates	Develop service-level data resources for use by Health Care Financing Administration	Service-level data from expert panels of physicians	(Survey cancelled by Health Care Financing Administration)

SOURCE: PPRC 1992b; Dunn and Latimer 1996; HER 1995; Levy 1996.

\* Physician time (or time plus direct costs) was preferred, but data were not available at time of study.

**Abt Associates Project.** HCFA contracted with Abt Associates to collect data on direct and indirect costs. Abt employed clinical practice expert panels (CPEPs) to develop direct cost relative values through an iterative group process. Abt also tried to obtain indirect cost data from a survey of physician practices. After the response rate on the first third of the survey was only 27 percent, HCFA decided to stop this phase of the Abt project. This has raised concerns among some groups that accurate relative values cannot be determined. The Commission has long advocated, however, allocating indirect costs in a manner that would not require these survey data.

The Abt project was designed to develop data from which other researchers could estimate values using alternative methods. HCFA is using the CPEP data as it crafts its proposed rule. The design and goals of the Abt project were described in more detail in the Commission's *Annual Report to Congress 1996* (PPRC 1996).

**Harvard Study.** HCFA contracted with Dunn and Latimer to consider approaches to developing new practice expense relative values based on existing data. The main emphasis of this project was the basis for allocating indirect costs. Harvard allocated indirect costs based on the physician time required to provide individual services. Because service-specific data on direct costs were not then available, direct



costs were allocated based on current practice expense relative values, which are themselves derived from historical charge levels.<sup>8</sup>

The Harvard approach uses three pieces of information: practice expense revenue shares by specialty, current practice expense relative values, and physician time. The revenue shares, which are the proportion of total physician revenue devoted to practice expense, are used to divide current relative values into direct costs and indirect costs.<sup>9</sup> The resulting direct cost values are used as is for each service, while the indirect costs are aggregated and then reallocated to services on the basis of physician time.

The Harvard method differs from the Commission's in two ways. First, Harvard allocated indirect costs with respect to physician time. Although the Commission would have liked to use time as a basis for allocation, these data were not available when its study was conducted, so it used the sum of physician work and direct costs to allocate indirect costs.

Second, Harvard based its direct cost values on current practice expense relative values—and therefore on historical charges—instead of on data about the direct costs for individual services. Therefore, the direct cost relative value for each service does not necessarily reflect the resources required to deliver that service. Although a specialty's total relative direct costs should be returned to it, those for particular physicians may not be, depending on the particular group of services they provide.<sup>10</sup> This problem would be more acute for subspecialists, because they furnish a narrower mix of services. By comparison, the Commission's approach should result in direct cost relative values that are accurate at the service level. Payment would reflect resource use, therefore, regardless of a physician's particular mix of services.

---

<sup>8</sup> Current fee schedule practice expense relative values are the product of a service-level practice expense revenue share and historical charge levels. The service-level revenue share is calculated as the volume-weighted average of the revenue shares of the specialists who provide the service.

<sup>9</sup> Under the Harvard approach, a service-specific direct cost share is developed based on revenue data from national physician surveys describing the share of total revenues that is accounted for by direct costs for different physician specialties. These specialty-specific shares are then used to calculate service-specific shares, based on the frequency with which each specialty provides the service. This service-level direct cost share is next used to divide current practice expense relative values into direct and indirect components.

<sup>10</sup> For example, if revenue data reveal that practice expenses account for 52 percent of ophthalmologists' total revenues, this does not necessarily mean that each service provided by an ophthalmologist requires practice expense resources that account for 52 percent of all resources used. The 52 percent is an average across the spectrum of services provided, including some that may incur few or no direct costs and others that require expensive supplies or equipment. If every ophthalmologist had a case mix that mirrored the average case mix precisely, it would not be necessary to use service-level practice expense values for individual physicians to be paid appropriately. If, however, direct costs vary significantly across services, and if individual ophthalmologists provide different mixes of ophthalmologic services, then use of relative values that do not capture the service-level differences would result in relative overpayment of some ophthalmologists and underpayment of others.

In the aggregate, the Harvard estimates lead to redistributions across specialties that are fairly similar to those estimated by the Commission (Table 13-5).<sup>11</sup> In particular, family practice and internal medicine realize gains in practice expense RVUs, whereas surgical specialties receive fewer RVUs in aggregate. The effects are nearly identical for cardiology, internal medicine, and orthopedic surgery. The Harvard approach, by contrast, leads to steeper declines for gastroenterology and general surgery. The largest difference in expected effects is for ophthalmology, which would lose only 8 percent of practice expense RVUs under the Harvard approach, compared with more than 20 percent under the Commission's estimates.

**Table 13-5. Ratio of Harvard Study Estimates to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty**

Specialty	Ratio of Harvard to Fee Schedule Value for:	
	Practice Expense Relative Value Units	Total Relative Value Units
Primary care		
Family practice	1.23	1.09
Internal medicine	1.15	1.06
Other medical		
Cardiology	0.80	0.90
Gastroenterology	0.59	0.81
Surgical		
Cardiac surgery	0.33	0.67
General surgery	0.68	0.87
Ophthalmology	0.92	0.96
Orthopedic surgery	0.69	0.85
Thoracic surgery	0.40	0.71

SOURCE: Dunn and Latimer 1996.

NOTE: Estimates reflect 1994 service volumes and 1996 relative value units (RVUs).

**HER Study.** HCFA also contracted with HER to study the use of existing data sources to develop resource-based practice expense relative values. The HER approach is based on the simple notion that at the service level, work and practice expense relative values should mirror their respective revenue shares. Like the current charge-based practice expense relative values and the Harvard approach, service-level revenue shares are calculated as the volume-weighted average of shares for the specialists who provide the service. These shares are used with the existing physician work relative value to calculate the total practice expense relative value for each service. If, for example, the work value for a service is one RVU and the practice expense share for that service is 50 percent, then the HER approach would yield a practice expense relative value of one RVU. If the work value is one RVU and the practice expense share is

<sup>11</sup> The comparison is for the Harvard estimates that include service specific site-of-service payment differentials similar to those used by the Commission (Harvard's base method used HCFA's current 50 percent reduction policy). The comparison is somewhat problematic for two reasons. The Harvard report includes a detailed breakdown of specialties, while the Commission aggregated some specialties. In addition, the Harvard estimates are compared with 1996 fee schedule values, while the Commission's earlier work reflects 1992 values.

67 percent, then the practice expense value would be two RVUs. This approach ensures that for each service, the ratio of the work and practice expense relative values equals the ratio of the net income and practice expense revenue shares.

In effect, the HER method allocates total practice expense relative values based on physician work. Practice expense resources required by a given service do not necessarily correlate with the physician work needed to provide the service, however. Thus, this approach does not necessarily yield resource-based values at the service level. The aggregate practice expense relative values for an entire specialty should be relatively correct. As with the Harvard approach, though, physicians furnishing different mixes of services within a specialty may not receive appropriate amounts of aggregate practice expense relative values.

The HER approach leads to redistribution of RVUs across specialties similar to the Commission's estimates for family practitioners, gastroenterologists, and orthopedic surgeons (Table 13-6).<sup>12</sup> It leads to a smaller decline for cardiologists than the Commission's method, but to larger changes for internal medicine and general surgery. HER's method also increases RVUs to ophthalmologists, who would receive reductions under both the Commission and Harvard approaches.

**Table 13-6. Ratio of Health Economics Research Study Estimates to Medicare Fee Schedule Practice Expense and Total Relative Value Units, by Type of Service and Specialty**

Specialty	Ratio of Health Economics Research to Fee Schedule Value for:	
	Practice Expense Relative Value Units	Total Relative Value Units
Primary care		
Family practice	1.35	1.14
Internal medicine	1.26	1.10
Other medical		
Cardiology	0.92	0.96
Gastroenterology	0.71	0.87
Surgical		
Cardiac and thoracic surgery	0.41	0.68
General surgery	0.67	0.85
Ophthalmology	1.11	1.05
Orthopedic surgery	0.71	0.85

SOURCE: Pope and Burge 1996.

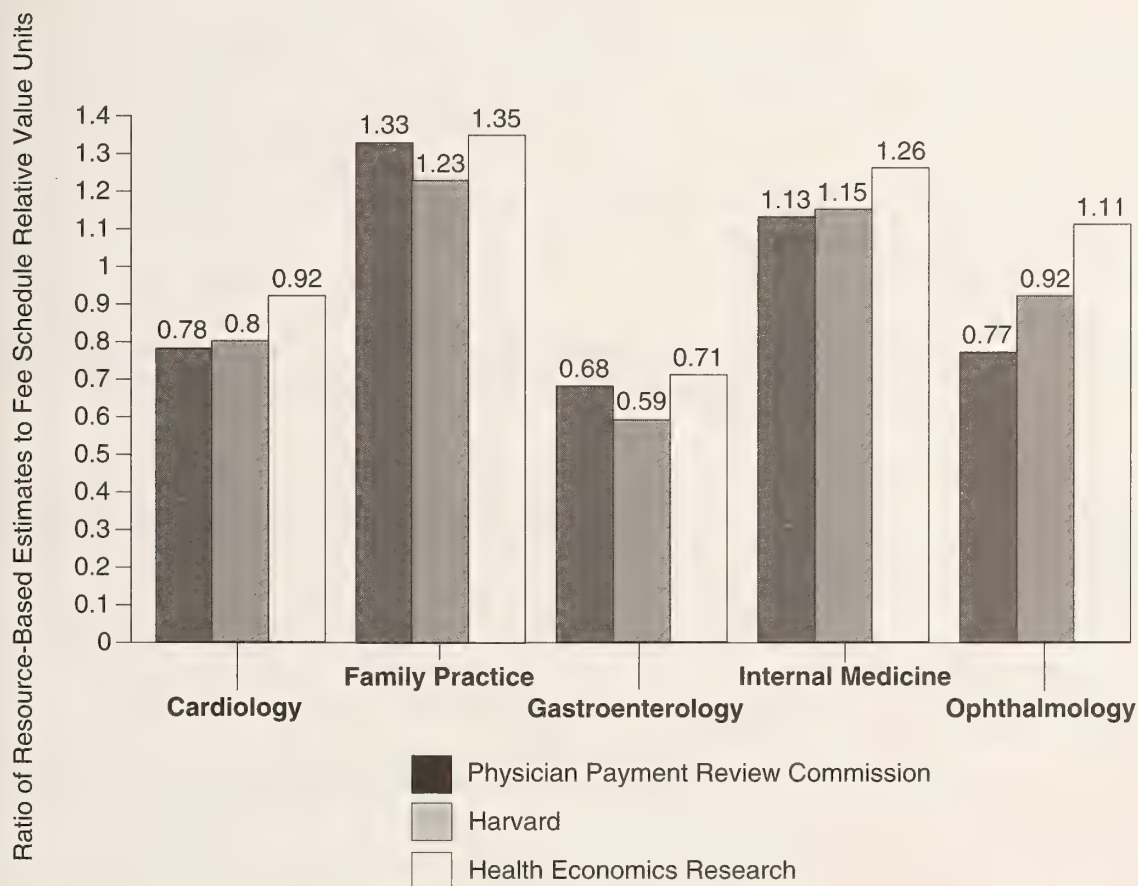
NOTE: Estimates reflect 1994 service volumes and 1996 relative value units (RVUs).

<sup>12</sup> The comparison is for the HER estimates that include service-specific, site-of-service payment differentials similar to those used by the Commission (HER's base method used HCFA's current 50 percent reduction policy). The comparison is somewhat problematic for two reasons. The HER report includes a detailed breakdown of specialties, while the Commission aggregated some specialties. In addition, the HER estimates are compared with 1996 fee schedule values, while the Commission's earlier work reflects 1992 values.



**Comparison of the Three Approaches.** The three sets of relative values lead to redistributions of RVUs across specialties that are—with some notable exceptions—fairly similar (Figure 13-1; Tables 13-3, 13-5, and 13-6). This does not necessarily indicate, however, that the three approaches result in similar RVUs at the service level. The Harvard and HER studies do not capture service-level differences in resources. That is because they employ aggregate data and averages, rather than information on the actual resources required to provide each service. Because direct costs vary across services, physicians who provide different mixes of services might be relatively underpaid or overpaid. By contrast, the Commission's approach was designed to make sure that service-level differences in direct costs were reflected in the relative values.

**Figure 13-1. Comparison of Three Estimates of Resource-Based Practice Expense Relative Values, for Selected Specialties**



SOURCE: PPRC 1992b; Dunn and Latimer 1996; HER 1995.

NOTE: Physician Payment Review Commission estimates reflect a more limited group of services than the other two, and its estimates for family practice includes general practice. Harvard and Health Economics Research estimates are for the site-of-service option similar to that reflected by the Commission approach, not for current Health Care Financing Administration policy. Commission estimates are compared to 1992 fee schedule relative values; Harvard and Health Economics Research estimates are compared to 1996 fee schedule relative values.

It would be useful to know whether the actual variation in direct costs among services is large enough to warrant collecting data on service-level direct costs as the Commission envisioned. If the variation is sufficiently small, extant aggregate data and averages alone can be used without producing significant errors at the service level. The three studies afford an opportunity to investigate this question. Because the Commission collected service-level direct cost data for its study, its results presumably reflect the actual variation in direct costs among different services. These results can be compared for the same services with those of Harvard and HER, which used a similar framework and relied on existing data sources that did not contain service-level information.

Accordingly, the Commission compared service-level estimates of direct costs from each of the three studies for office-based services. Because of the limited number of services included in the Commission's original study and changes in service codes since that time, only 112 office-based codes could be analyzed. The comparisons demonstrate that the Harvard and HER approaches result in service-level direct cost relative values that are much more highly correlated with each other than either is with the Commission's direct cost relative values (Table 13-7). The 0.55 correlation coefficient between the Harvard and the Commission estimates suggests that either one could explain only about 30 percent of the variation in the other; the correlation between the HER and Commission estimates is even lower.<sup>13</sup> If the Commission data reflect service-level differences in direct costs, these low correlations suggest it may be difficult to capture service-level variation in direct costs without obtaining appropriate service-level data.

**Table 13-7. Correlation Coefficients among Physician Payment Review Commission, Harvard Site-of-Service, and Health Economics Research Site-of-Service Direct Cost Relative Values**

Organization	Physician Payment Review Commission	Harvard	Health Economics Research
Physician Payment Review Commission	1.00	0.55	0.46
Harvard		1.00	0.82
Health Economics Research			1.00

SOURCE: Physician Payment Review Commission analysis.

NOTE: Correlations are based on the 112 office-based services included in all three studies.

The total practice expense relative values under each of the three approaches are more highly correlated for two reasons. First, the indirect cost allocation bases are more strongly correlated than the direct cost values. Second, indirect costs account for a large share of total practice expense values. Total relative values under the three approaches are even more similar, since practice expenses account for only about 41 percent of payments, on average.

<sup>13</sup> The square of the correlation coefficient reveals the percentage of variation in one variable that is accounted for by the other.

**Implications for Development of Resource-Based Practice Expense Relative Values.** The Commission continues to recommend that HCFA develop direct cost relative values based on data on service-level direct costs, and that indirect costs be allocated by one of the available valid methods. The evidence described above implies that it would be difficult to develop practice expense relative values that capture service-level differences in resource use without service-level direct cost data. Although the Commission had previously envisioned a widescale data collection effort from physician practices, the small group process Abt Associates used to develop direct cost relative values should have been able to capture service-level differences in practice expenses. These data were made available in time for HCFA to use in developing proposed regulations in 1997.

HCFA must choose among several alternative methods for allocating indirect costs. The Commission has recommended that the basis for allocating indirect costs should be incentive neutral; that is, physicians should not face financial incentives to provide some services in place of others. Within the context of the fee schedule, several analytically appropriate methods would meet this criterion. The Harvard study makes the case that physician time is the appropriate basis, guaranteeing that physicians generate some payment for overhead cost for each minute they spend with patients. Time plus direct costs may be even more appropriate, since the relative return per unit of resources would be equal across all services. The HER report states that physician work alone is appropriate, arguing that practice expenses are likely to be higher for those services characterized by more work relative to time (HER 1995). The Commission disagrees with this reasoning. Work could be justified on the basis that it would guarantee that physicians generate overhead payments per unit of work. Work plus direct costs would be preferable, however, because it would include a broader group of resources. This would minimize the distortions in incentives that work alone may introduce.

Even though these projects provide HCFA with insight into the effects of different allocation bases, ultimately the selection of a method will depend on policymakers' judgment. No one correct method exists, and no analytic tools are available that would dictate the choice. Instead, HCFA must consider factors like data availability and reliability, payment incentives, and policy goals. The method should be acceptable to physicians so that the resulting values are credible.

That the Commission, Harvard, and HER derived generally similar effects has led the Commission to conclude that existing data are sufficient to begin the process of implementation in 1998. If a multi-year transition and a refinement process are used, then launching the process in 1998 based on these gross estimates will move most relative values in the correct direction toward their final resource-based values. Such an approach mirrors the overvalued procedure reductions that preceded implementation of the Medicare Fee Schedule. It would start to remedy the longstanding inequities caused by the continued use of charge-based practice expense relative values.

### **Concerns About the Practice Expense Relative Values Development Process**

Various issues have been raised about the process HCFA is using to develop new practice expense relative values. HCFA chose a different strategy to develop resource-based practice expense relative



values from the one proposed by the Commission. Since the Commission has always favored allocating indirect costs according to an available appropriate method, it disagrees with others that discontinuing the indirect cost survey threatens the validity of new relative values. Similarly, the use of small groups to develop direct cost values, although different from the Commission's recommended approach, is not inherently inappropriate.

Over the past few years, HCFA has met with its technical expert group (TEG) and with specialty societies to get input into its work. At a meeting in January 1997, HCFA staff presented some preliminary results based on the CPEP data on direct costs and alternative indirect cost allocation methods. Inasmuch as the estimates were considered very preliminary and included a variety of scenarios, they may not be indicative of the values that actually will be included in the forthcoming proposed rule. After this meeting, HCFA encouraged interested parties to comment on the CPEP data to help the agency develop its proposed rule. Those trying to do this had problems acquiring and using the data. As a result, many missed the agency's deadline for feedback. HCFA will continue to accept comments beyond its original deadline to give involved parties a chance to analyze these data.

As the process of developing values nears completion, various groups have raised issues about the process and its results. Their concerns address four areas: estimating direct costs, allocating indirect costs, combining direct and indirect costs, and implementing new values. With regard to developing direct cost relative values, one outstanding technical issue will affect final values—linking values from different CPEPs. Each CPEP established values for distinct groups of codes, and HCFA is now considering how to combine the disparate results into a common scale. This is the same kind of issue that arose when physician work values were developed by individual specialties using different scales. The scales ultimately were combined into one in an acceptable manner. Other comments about direct costs have questioned the fundamental appropriateness of the CPEP process, the face validity of its results, and the accessibility of the CPEP data.

The main issue concerning indirect costs is the basis used for allocation. Because HCFA's preliminary results illustrated several approaches, it is still not clear how the agency plans to proceed.

Creating total practice expense values from direct and indirect costs requires a decision about the share of total practice expenses accounted for by each. The Commission has consistently suggested that this should be determined by how direct costs are defined. In its earlier study, the Commission categorized clinical labor, medical equipment, and medical supplies as direct costs (PPRC 1992b). Its analyses were based on available survey data, which suggested that these costs constitute about one-third of total practice expenses. Similarly, HCFA should determine what share of total practice expenses are represented by the costs included in the CPEPs' analysis. The direct and indirect cost values should be combined accordingly.

Finally, many are concerned about implementation of the new practice expense values. Some report that the expected changes in payment are much larger than they originally anticipated, threatening beneficiaries' continued access to certain services and types of care. Because important decisions have

yet to be made and proposed values issued, it is difficult to analyze how these values will affect total payments. If the expected payment changes turn out to be large, this would only underscore the inaccuracy of current values. Other groups' demands for immediate implementation would be strengthened. However, the Commission's call for a multiyear transition reflects concern about the possible effects of extraordinarily large payment changes.<sup>14</sup>

A second implementation issue observers have raised is the size of the adjustment applied to all payments to offset any changes in physicians' behavior when payments change. The Commission has found that the behavioral offset used to set payments when the fee schedule was first introduced was too large (PPRC 1993). It encourages HCFA to be guided by this finding in establishing payment rates in 1998. The Commission disagrees, however, with those who do not think there should be a behavioral offset. Without one, total Medicare payments would probably change, contrary to the legislative requirement of budget neutrality.

These issues have led to widespread concern about the acceptability of new resource-based practice expense relative values and to calls for delaying their implementation. Although the Commission offered a different approach to developing values, it does not think implementation should be postponed. Because alternative data sources and analytic methods are not currently being developed, nothing would be gained through a delay. In addition, delay would perpetuate the inequities that underlie the current method. Even if the new values were imperfect, they are likely to reflect relative resource use more accurately than the current values do. The combination of an inclusive refinement process and a multiyear transition would enable the process to be started now, but would allow the values to be improved before they are fully implemented.

## **THE FIVE-YEAR REVIEW OF WORK RELATIVE VALUES**

OBRA89 requires HCFA to review all relative values every five years to ensure their accuracy. The first review was completed in November 1996, and the new values were used to pay physicians in January 1997. The review focused exclusively on the work relative values, because resource-based values for practice expense are still being developed, and the malpractice expense relative values remain charge-based.

The review seems to have made the work relative values substantially better, although HCFA is still working on a few remaining issues. Involved parties should now give thought to how to improve the process for the next review.

---

<sup>14</sup> If implementation of the new values is delayed contrary to the Commission's recommendation, the duration of the phase-in should be shortened accordingly. Providers who will experience large payment reductions can use the delay to prepare for these changes, so the full three-year phase-in will not be necessary.

This section highlights the results of the review and analyzes outstanding issues concerning the process. The budget neutrality adjustment required to implement the new values is also considered. The last section identifies areas in which the process might be improved for the next review, due by the year 2002.

### **The Five-Year Review Process**

Physician work is determined by factors such as the time, skill, intensity of effort, and risk to the patient associated with providing a service. There is no gold standard by which to measure physician work precisely. Consequently, the credibility of the relative value scale rests on the quality of the process used to determine the relative values.

The process HCFA used for the five-year review accorded reasonably well with principles elaborated previously by the Commission (PPRC 1995).<sup>15</sup> HCFA identified some 1,000 services to be reviewed in depth, based on suggestions from professional organizations and the public. It referred these services to a multispecialty committee convened by the American Medical Association, called the AMA/Specialty Society Relative Value Update Committee (RUC). The RUC considered evidence such as surveys of physicians, comparisons with other services, problems identified with the methods used to determine existing values, and changes in work that have occurred since the scale was originally created. To recommend a change in the value of a service, two-thirds of the committee were required to find the evidence of error "compelling." Specialty societies requested many more increases than the RUC ultimately accepted as being justified by compelling evidence, and at times the committee recommended a new value that differed from the one requested by a specialty society. The committee referred some codes to the Current Procedural Terminology (CPT) Editorial Panel for coding revisions before new values were assigned, and transmitted to HCFA recommended values for the remaining codes.

HCFA convened refinement panels to review the RUC's recommendations. Similar to the panels used for the annual update process for new and revised codes, these panels comprised carrier medical directors, HCFA staff, and RUC representatives who answered questions about the committee's recommendations. HCFA ultimately accepted more than 95 percent of the changes recommended by the RUC. The results of the agency's deliberations were published as proposed values in May 1996 (HCFA 1996a). After reviewing public comments, the new work relative values were finalized for use in 1997 (HCFA 1996c). The entire process took two years.

### **Results of the Review**

Of the 1,124 services involved in the review, the work values of 314 were elevated. Payment for 250 anesthesia services was also raised through an increase in the anesthesia conversion factor. Work

---

<sup>15</sup> The Commission suggested that the process include (1) mechanisms to promote consistent decisionmaking, (2) fair methods and representation of involved parties, (3) means to identify overvalued as well as undervalued services, (4) ways to ensure public accountability, and (5) feedback to the Current Procedural Terminology Editorial Panel when codes need revision to achieve accurate resource-based payment (PPRC 1993).



values for 135 services were decreased; for 607 the values were not changed. HCFA and the RUC referred 68 services to the CPT Editorial Panel for coding changes before new values are assigned, and some issues were deferred for future consideration. Because more values were increased than were decreased, a sizeable budget neutrality adjustment of -8.3 percent was applied via a special work adjuster (described below).

In addition to correcting specific misvalued services, the review addressed systematic problems some believed existed in the scale of relative work. These included compression of the differences in value between simple and complex services, as well as undervaluation of the anesthesia conversion factor, evaluation and management services like office and hospital visits, and EM services included in global surgical services.

**Compression of the Differences in Value Between Simple and Complex Services.** Some surgical specialty societies believe that the process used to determine the initial work relative values systematically undervalued highly complex procedures compared with simple ones. The five-year review remedied that problem comprehensively in neurosurgery. The RUC and HCFA both accepted a unified revision that involved 73 neurosurgical codes, which was submitted by the American Association of Neurological Surgeons/Congress of Neurological Surgeons. Other specialties addressed the problem by seeking the revaluation of specific services.

**Evaluation and Management Services.** The RUC recommended substantial increases in the work values for EM services. Primary care specialty societies had provided compelling evidence that these services have become more difficult since the original relative value scale studies were conducted by Hsiao and his colleagues at Harvard in the late 1980s. The changes were attributed to factors such as shorter lengths of hospital stays, greater complexity of patients in inpatient and outpatient settings, more documentation and case management requirements, and increased information provided by physicians to patients during the visits.

EM services were also thought to have been undervalued relative to procedural and surgical services since the inception of the relative value scale. A study sponsored by the American College of Physicians demonstrated that the work intensity (number of relative value units per minute) of EM services was less than that of 96.5 percent of all other services (Cleaveland 1995). The work intensity of EM services was equivalent to that of ear wax removal—a procedure clearly requiring less skill and cognitive effort than, say, a new patient evaluation.

HCFA agreed that many EM services were undervalued, but adopted a somewhat different pattern of increases than the RUC recommended. Using a different method to calculate new work values, HCFA increased the work values of EM services by about 16 percent overall (before the budget neutrality adjustment was applied).

Despite these substantial increases, the five-year review had a relatively modest effect on overall payments to primary care specialties (Table 13-8). Family practice physicians, for example, will see a net 2.5 percent increase in payments. This attenuation occurs for three reasons. First, work represents only about half of total RVUs, and the practice expense component was unaffected by this review.

**Table 13-8. Effect of the Five-Year Review on Medicare Fee Schedule Payments, by Specialty**

Specialty	Change in Payments:	
	Percent	Dollars (millions)
Primary Care		
Family practice	2.5%	\$ 55
General practice	1.4	15
Internal medicine	2.1	102
Other Medical		
Cardiology	-0.5	-17
Emergency medicine	1.7	10
Gastroenterology	-1.6	-18
Hematology/oncology	1.9	8
Nephrology	-3.4	-14
Neurology	0.6	3
Psychiatry	3.6	31
Pulmonary	1.6	13
Rheumatology	1.2	2
Surgical		
Cardiac surgery	-4.0	-10
Dermatology	-4.3	-36
General surgery	-2.5	-48
Neurosurgery	-1.7	-6
Obstetrics/gynecology	0.3	1
Ophthalmology	-5.5	-210
Orthopedic surgery	-3.4	-64
Otolaryngology	-0.8	-4
Plastic surgery	-3.2	-6
Thoracic surgery	-3.5	-24
Urology	-3.2	-36
Vascular surgery	-1.0	-2
Other		
Anesthesiology	5.2	64
Pathology	-5.7	-30
Radiation Oncology	-4.8	-20
Radiology	-4.4	-120
Non-Physician Providers		
Chiropractor	15.5	40
Optometrist	-5.1	-12
Podiatry	-4.3	-37
Total	-0.9	-371

SOURCE: HCFA 1996c and unpublished American Medical Association analysis.

NOTE: These figures include all budget neutrality adjustments but not the volume and intensity increases anticipated by the behavioral offset. They do not reflect the conversion factor updates for 1997. Dollar impact is based on 1994 allowed charges. The total effect of -0.9 percent is due to the behavioral offset.

Second, many nonprimary care specialties bill for EM services. That caused a larger budget neutrality adjustment to be applied to all services—including those provided by primary care physicians. Third, the five-year review increased the work values for a number of non-EM services, which also contributed to the budget neutrality adjustment that was applied to all services. The gains in payment for stand-alone EM services would be further contracted if the values for the EM components of global surgical services were raised in the future (discussed below).

**Evaluation and Management Components of Global Surgical Services.** Global surgical service packages typically include evaluation and management services like postoperative hospital and office visits. Some groups suggested that because the five-year review raised the values for most EM services, the values for the EM components of global surgical services should be similarly increased.

Primary care specialty societies argued that increases for global surgical services would contradict one of the rationales that justified the changes for EM services, namely, that EM services were undervalued with respect to procedural and surgical services. They also contended that EM services in global surgical services were different from nonsurgical EM services. The elements of work that had increased in EM services may not be present at all or to the same degree in the EM components of global surgical services.

The RUC, the American Medical Association, and others concluded that although the EM components of global surgical services should be revalued, a direct translation from nonsurgery-related EM services was not necessarily correct. More data were needed to determine whether new values were appropriate and what they should be.

The latter approach seems correct. Identical work should be valued the same, but the work of EM services in global surgical services is not likely to be identical to that of separately billed EM visits. The increased documentation now needed to bill for separate EM services, for example, is not required for EM services that are bundled into a global surgical package. Postservice work covers all work until the next visit for stand-alone EM services, a period that can last up to a year or longer. Intervals between the visits included in global surgical packages are much shorter.

Another factor complicating the translation of payment increases for EM services into global surgical services is that the EM content of global surgical services was estimated imprecisely when the fee schedule was first derived.<sup>16</sup> In addition, changes have occurred in the EM content of surgical services since the inception of the relative value scale, such as a reduction in length of hospital stays for many procedures.

---

<sup>16</sup> The American Academy of Otolaryngology and Head and Neck Surgery noted in its comments on the May 1996 proposed rule that Harvard and HCFA did not use a pure building-block approach in valuing surgical services. Preservice and postservice work were valued by Harvard—at least for some codes—by subtracting estimates of intra-service work from estimates of total work. Written testimony submitted to the Commission by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons (AANS/CNS) states that, based on data they compiled for the five-year review, the original Harvard study seriously underestimated the amount of preservice and postservice work by not including intensive care unit and other visits that occurred within the global period (AANS/CNS 1996).



After reviewing additional data, the RUC has recommended to HCFA that postoperative hospital visits receive the same increase in value as the corresponding stand-alone hospital visits. Postoperative office visits would receive somewhat less than the increase granted to the corresponding stand-alone office visits (Seward 1997).<sup>17</sup> The RUC also recommended updating the number of postoperative hospital visits for each global surgical service. HCFA is now considering these recommendations.

**Anesthesia Codes.** The American Society of Anesthesiologists proposed raising anesthesia codes' work values by 34.8 percent. It based that recommendation on a study by Abt Associates, Inc. in which values were derived for the intensity (work per unit time) of work during different stages of anesthesia services (preanesthesia, induction, procedure, emergence, and postanesthesia). The RUC accepted the new intensity values, except those proposed for the time during the procedure itself. For that component, the RUC lowered the minimum intensity from 0.025 to 0.017. Work values would then increase by 22.76 percent. HCFA accepted the increase because of the thoroughness with which the RUC had examined these services. Anesthesiology thus received the highest net percentage increase in payment of any physician specialty (Table 13-8).

### **Budget Neutrality Adjustment**

Net increases in work relative values stemming from the five-year review required an 8.3 percent across-the-board reduction in all work relative values to keep the changes budget neutral. Rather than reducing the actual work relative values, HCFA created a special "work adjuster" that Medicare will apply to the work relative value units for each service when it calculates payment amounts (i.e., the work relative value will be multiplied by 0.917). The rest of the calculation of the total relative value for each service remains the same. This strategy preserves the absolute relative value units of services not changed in the five-year review, which benefits others using the relative value scale. This special work adjuster was widely approved by specialty societies and is consistent with previous Commission recommendations.

Because work is only one component of the total relative value for a service, the work adjuster will reduce by 4.6 percent Medicare's total payment for an average service. HCFA lowered the conversion factors an additional 0.9 percent for the behavioral offset. HCFA notes that this 0.9 percent was added to the volume performance standard for 1997. If the anticipated increases do not occur, therefore, a future update will correct for this. The conversion factors were reduced by an additional 0.6 percent to account for other payment policy changes contained in the final rule, including changes in the payment localities and geographic adjustment factors. The size of the combined budget neutrality adjustments (-6.1 percent) had a major effect on the net payment changes for each specialty (Table 13-8).

---

<sup>17</sup> The intra-service (face-to-face) work of postoperative office visits was given the full increase accorded the intra-service work of the corresponding stand-alone office visit, but the post-service work was increased by only half of that of the corresponding stand-alone office visit. The difference was attributed to the decreased documentation and other post-service work associated with stand-alone office visits (Doherty 1997).

The separate work adjuster will be eliminated in 1998 when the new resource-based practice expense relative values are instituted. HCFA intends to make future budget neutrality adjustments on the conversion factors rather than on the work values. Its decision reflects the preferences of specialty societies and at least two private payers that commented on the final rule. The Commission has previously recommended that budget neutrality adjustments for Medicare-specific payment policy changes be made on the conversion factors (PPRC 1995).

Over time, making the budget neutrality adjustment on the conversion factors rather than on the refined relative values may disturb the relationship among the three components of the relative value scale. HCFA avoided this problem in the five-year review by using the special work adjuster. In the future, most relative value changes will probably be made to all three components of a service. Although changes in one component will not necessarily be correlated with changes in another, the resulting distortions to the relationship among the three components will probably be tolerable on a yearly basis. Over time, however, the distortions may cumulate, making even more salient the need to periodically recalibrate the respective revenue shares of the three components (discussed below).

**Issues HCFA Will Address Before the Next Five-Year Review.** HCFA reaffirmed its intention to review some aspects of the relative value scale before the next five-year review gets under way. These include the EM component of global surgical services, services typically requiring more than one code to be described correctly, the relationship of physician work between analogous open and closed procedures, radiation oncology, and rank-order anomalies within families. The rule does not discuss plans for the process to be used for the forthcoming five-year review.

### **Preparing for the Next Five-Year Review**

Now that the first five-year review has been completed, the process can be assessed. Problems perceived by many specialties have been largely corrected by the review process. In neurosurgery, the RUC and HCFA both accepted a revision that fixed the compression in values for 73 services. HCFA responded to the concerns of specialty societies by changing some disputed values. The success of this effort seemed apparent at the Commission's December 1996 hearing: Not one physician specialty society complained in written testimony about the results of the five-year review process in valuing individual codes.

Professional organizations have already begun to propose improvements for the next review. The American Academy of Orthopaedic Surgeons, for example, has suggested lengthening the timetable for the process to permit a more in-depth analysis of each service (DeHaven 1996). The Commission has identified several areas that should be addressed to improve the review of work relative values. Other issues concern the integration of the review of practice expense and work relative values and the need to recalibrate the revenue shares of the three components.

**Improving the Review of Work Relative Values.** Several areas should be addressed before the new review. One is the means to identify overvalued services. The five-year review raised the values for more than twice as many services as it decreased. The large reduction in work values needed to



maintain budget neutrality underscores the extent of the asymmetry (although most of this was due to the high volume of EM services that received increases). Asymmetry causes services not involved in the review to be passively decreased in value because of the budget neutrality adjustment. Specialty societies thus have an incentive to seek increases in values for at least some services just to stay in place. It would be desirable to remove this incentive and make the relative value scale more accurate by better identification of overvalued services. An additional benefit would be a reduction in the size of any necessary budget neutrality adjustment.

Means are needed to identify families of services that are valued incorrectly. The five-year review process seemed to work best when comparing individual services with related ones. The ability to assess the relative placement of families of services in the scale of relative work is also needed.

HCFA, the RUC, and others have by now gained considerable experience in the task of valuing codes. It should be possible to explore ways to obtain better data to support this task, including who should collect it and how it would be financed. In particular, data on intensity of work need to be refined and the use of such data better defined. The reference set of services, which is used as a benchmark for comparisons to other services, was itself subject to change during the first five-year review. Because this is such a key component of the process, it should be refined before individual services are reviewed.

**Integration of Review of Work Relative Values with Practice Expense Values.** After practice expense relative values become resource-based, both should probably be reviewed simultaneously during future five-year reviews. Challenges may be posed by carrying out both reviews at the same time. If indirect costs are based in part on physician work, for example, they must await completion of work relative value changes.

**Recalibration of the Respective Revenue Shares of the Work, Practice Expense, and Malpractice Expense Components.** The proportionate shares of the three components of the fee schedule are still based on 1989 data suggesting that 54.2 percent of revenues were accounted for by physician net income (physician work), 41.0 by practice expenses, and 4.8 percent by malpractice expenses. More recent information indicates that the relative share of practice expenses has grown significantly since then. The five-year review would be an appropriate time to rebalance the shares of the three components. This would account for changes over time and correct for the distortions introduced by using the conversion factor to make budget neutrality adjustments.

## **FEE SCHEDULE PAYMENT AREAS**

Payments made under the Medicare Fee Schedule are adjusted for local price variation.<sup>18</sup> Every state has one or more geographic payment areas. For every service in the fee schedule, each payment area

---

<sup>18</sup> Before the three components of the fee schedule—work, practice expense, and malpractice expense—are added together to form the total relative value for a service, each component is multiplied by the applicable geographic practice cost index (GPCI). This adjusts for the relative cost of resource inputs for each component in each payment area. There is a separate GPCI for work, practice expense, and malpractice expense in each payment area. In Santa Clara County, CA, for example, the work GPCI is 1.064, the practice expense GPCI is 1.289, and the malpractice GPCI is 0.596 (HCFA 1996c).



has its own price adjuster called a geographic adjustment factor (GAF).<sup>19</sup> Medicare's reimbursement levels, therefore, are uniform within each payment area but vary among areas. Physicians in Manhattan, for example, are paid 34 percent more for a level 3 established patient office visit (CPT Code 99213) than physicians in South Dakota.

The payment areas must be drawn carefully to ensure that Medicare pays physicians fairly and that payments to Medicare risk plans are tied accurately to local fee-for-service Medicare expenditures.<sup>20</sup> HCFA revised the payment areas for 1997 (HCFA 1996c). Previously, there were 210 fee schedule payment areas nationwide. HCFA combined many payment areas—in some instances, into a single statewide area. These changes reduced the number of payment areas to 89.

The rest of this section describes the reason for the changes and the process HCFA used to make them. It then analyzes the results of the revision and raises two concerns with the agency's approach.

### **How and Why the Payment Areas Were Revised**

The previous payment areas were derived from the localities used by Medicare carriers under the customary, prevailing, and reasonable (CPR) charge-based payment system that preceded the fee schedule. Because these areas were originally defined in response to various economic, political, and administrative considerations, their size and population varied widely. Some states each constituted a single statewide area, while one state was divided into more than 30 areas.

These historical payment areas did not meet the needs of the Medicare Fee Schedule's resource-based approach to payment. Fee schedule payment areas should delineate where input prices are uniform and, therefore, the same geographic adjustment factor can be applied. The historical payment areas were never intended to serve these purposes.

The Commission has used three criteria to evaluate alternative approaches to defining payment areas: accuracy in tracking variation in prices, the magnitude of payment differences at payment area boundaries, and the administrative and conceptual simplicity of the approach. The criteria reflect the Commission's belief that geographic payment adjustments are intended only to reflect input price variations across the country. Other policy goals should be addressed explicitly through other means, like the bonus payments used to encourage physicians to serve beneficiaries in underserved communities.

After assessing different approaches, the Commission has recommended basing the payment areas on metropolitan statistical areas (MSAs) (PPRC 1991). This would satisfy the Commission's criteria; in

---

<sup>19</sup> Because each service has its own GAF in each payment area, the GAF for a typical service is an analytic construct useful for analyzing alternative payment areas. The typical GAF is the average of each area's three GPCIs weighted by the proportionate shares each component contributes to total relative values.

<sup>20</sup> The link between Medicare fee-for-service payment areas and the Medicare risk-contracting program is discussed in detail in Chapter 14 of the Commission's *Annual Report to Congress 1996* (PPRC 1996).

particular, it would avoid large payment differentials within heavily populated metropolitan areas that cross state boundaries.

HCFA did not adopt the Commission's recommended approach (HCFA 1996b).<sup>21</sup> Instead, it sought to identify where existing payment areas could be combined in the 28 states with multiple payment areas. In those states, the agency retained the historical payment areas whose GAFs differed from the rest of the state by 5 percent or more; the remaining payment areas were combined into one residual payment area.<sup>22</sup> HCFA preferred this approach because it is based on historical payment areas, reduces the number of separate payment areas, and tracks local price variation reasonably well. The agency also made ad hoc improvements in some payment areas.<sup>23</sup>

## Results of the Revision

The revision resulted in a total of 89 new payment areas that are simpler both administratively and conceptually (HCFA 1996c). Twelve new statewide payment areas were created, bringing their total to 34. The number of payment areas in the other states were reduced to a total of 55 (Table 13-9).

The geographic adjustment factors for the new areas were calculated to be budget neutral within each state. As a result, the new areas will not affect total payments to each state, but will redistribute payments within states.<sup>24</sup> The GAF went up in 43 percent of payment areas and declined in 33 percent. The size of the payment changes was modest. Of the 188 former payment areas in the 28 states involved in the revision, 154 experienced GAF changes of less than 3 percent; only eight had changes exceeding 5 percent (HCFA 1996b).<sup>25</sup>

---

<sup>21</sup> HCFA chose one of several alternatives analyzed by Health Economics Research, Inc., under contract with HCFA.

<sup>22</sup> The actual process involved an iterative analysis of historical payment areas' GAFs for a typical service. The highest GAF in the state was compared with the mean GAF in the remaining payment areas of the state. If the difference between the two was less than 5 percent, the state was made into a single statewide area. Otherwise, the high-GAF area was retained as a separate payment area, and the process was repeated for the next highest-priced area of the state. The process was stopped when the difference between the area's GAF and the mean GAF for the rest of the state fell below the 5 percent threshold. All remaining areas were combined into one (HCFA 1996b).

<sup>23</sup> HCFA redefined substate areas in those few states where payment areas did not respect county borders or could otherwise be improved. Payment areas that used city or ZIP code definitions were generally incorporated into larger areas under the revision; the rest were redefined to respect county borders. HCFA significantly redefined payment areas in Massachusetts, Missouri, and Pennsylvania, to avoid perverse results that would have been created by the 5 percent threshold method (HCFA 1996b).

<sup>24</sup> Payments to Medicare risk programs will also change in the affected areas, because those payments are based on fee-for-service Medicare expenditures in each payment area (PPRC 1996).

<sup>25</sup> The largest changes in individual GAFs resulted from the ad hoc redrawing of payment area boundaries in Massachusetts, Missouri, and Pennsylvania, rather than from combining previous payment areas.

**Table 13-9. Effect of Payment Area Revision on Number of Payment Areas by State**

State	Number of Payment Areas	
	1996	1997
Alabama	6	1
Alaska	1	1
Arizona	6	1
Arkansas	1	1
California	28	9
Colorado	1	1
Connecticut	4	1
Delaware	1	1
District of Columbia	1	1
Florida	4	3
Georgia	4	2
Hawaii	1	1
Idaho	2	1
Illinois	16	4
Indiana	3	1
Iowa	1	1
Kansas	3	1
Kentucky	3	1
Louisiana	8	2
Maine	3	2
Maryland	3	2
Massachusetts	2	2
Michigan	2	2
Minnesota	1	1
Mississippi	2	1
Missouri	7	3
Montana	1	1
Nebraska	1	1
Nevada	4	1
New Hampshire	1	1
New Jersey	3	2
New Mexico	1	1
New York	8	5
North Carolina	1	1
North Dakota	1	1
Ohio	1	1
Oklahoma	1	1
Oregon	5	2
Pennsylvania	4	2
Rhode Island	1	1
South Carolina	1	1
South Dakota	1	1
Tennessee	1	1
Texas	32	8
Utah	1	1



**Table 13-9.** (continued)

State	Number of Payment Areas	
	1996	1997
Vermont	1	1
Virginia	4	1
Washington	3	2
West Virginia	5	1
Wisconsin	11	1
Wyoming	1	1
<b>TOTAL</b>	<b>210</b>	<b>89</b>

SOURCE: HCFA 1996b.

NOTE: Maryland and Virginia payment areas do not include the two counties in Maryland and two counties and one independent city in Virginia that are part of the Washington, DC payment area.

HCFA will implement the new system over two years in areas where the GAF is slated to rise or fall by more than 4 percent. Only Missouri and Pennsylvania qualified for a transition. To maintain budget neutrality within these two states, the transition will apply to all of their substate payment areas.

In the 16 states that still contain more than one payment area, HCFA will continue its current policy with regard to petitions to merge all payment areas into one statewide area. Petitioning states must demonstrate widespread support for a statewide payment area among both winning and losing physicians. Six states have submitted successful applications since 1992; one petition was rejected because support was not sufficiently widespread.

### Concerns with HCFA's Approach to Revising Payment Areas

The new payment areas are notably improved from the previous ones. HCFA's approach to revising the payment areas raises two issues, however. First, the treatment of metropolitan statistical areas is problematic. Second, HCFA's approach overlooks demographic and economic changes that may warrant creation of new, smaller payment areas.

**Metropolitan Statistical Areas.** HCFA's treatment of MSAs is flawed in two respects. First, the historical payment areas used as building blocks by HCFA are not drawn with regard to MSAs. As a result, the new payment areas do not match many MSAs well. Every possible relationship exists between the new areas and MSAs: instances where the payment area is congruent with the MSA, where it includes only part of an MSA, and where it includes all of an MSA plus additional counties.

In some cases, the metropolitan area is divided into smaller payment areas that make sense for the purposes of the fee schedule. The payment areas for the Chicago MSA include one for Cook County, one for the suburban "collar counties" that surround Cook County, another for those in and near East St. Louis, and a fourth for all other areas (Figure 13-2). This arrangement permits the GAFs in the Chicago area to decline along an intuitively reasonable gradient from urban core to rural fringe.

**Figure 13-2. Counties of the Chicago Metropolitan Statistical Area, by Fee Schedule Payment Area**



**SOURCE:** HCFA 1996b.

**NOTES:** The Chicago metropolitan statistical area includes all of the Cook County and suburban Chicago payment areas and part of another payment area. The third payment area includes the rest of Illinois except the East St. Louis area.

GAF is the geographic adjustment factor for a typical service.

In many metropolitan areas, however, there are peculiar mismatches between the MSA and payment areas. The St. Louis MSA, for example, crosses the Illinois-Missouri border. The two halves of the MSA illustrate opposite problems. The East St. Louis, Illinois, payment area includes not only the five Illinois counties in the St. Louis MSA, but an additional six counties outside of the MSA (Figure 13-3). Consequently, in the Illinois part of the MSA, payment rates are the same within the MSA and outside of it. If input prices are lower in the adjacent counties than in the MSA—as is typically the case—these differences are not reflected in the GAF because the payment area is too inclusive.

**Figure 13-3. Counties of the East St. Louis Fee Schedule Payment Area, by Metropolitan Statistical Area Status**



SOURCE: HCFA 1996b.

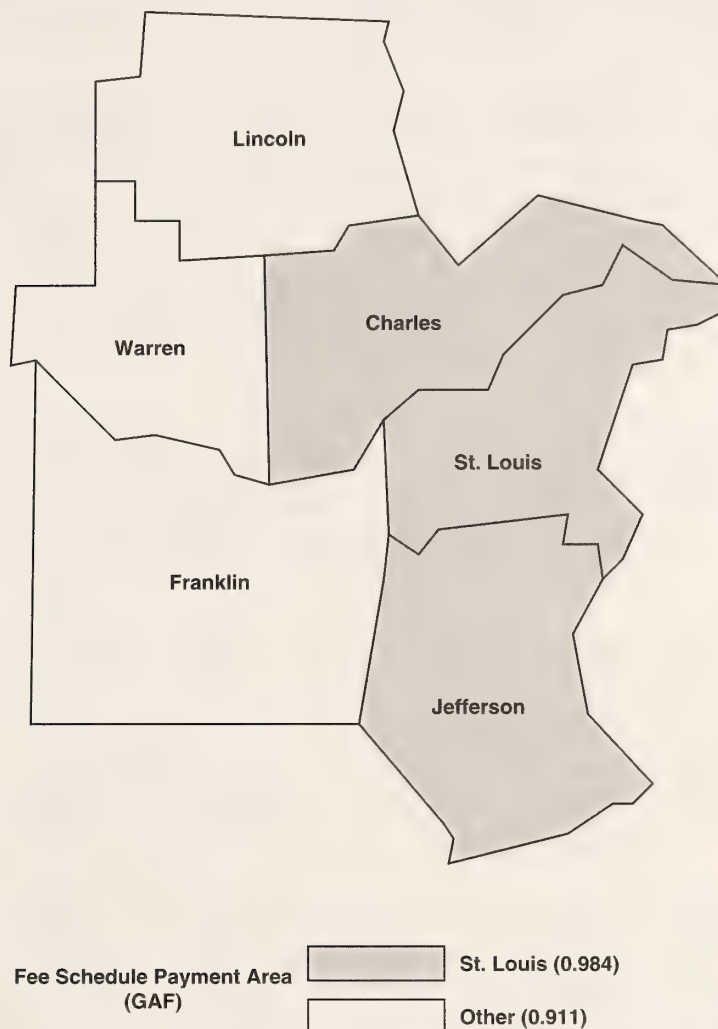
NOTES: The East St. Louis, IL, fee schedule payment area includes the five Illinois counties of the St. Louis MSA and six adjacent non-MSA counties.

The geographic adjustment factor is 0.974.

Conversely, the St. Louis, Missouri, payment area includes only the city itself and three adjacent counties, whereas the MSA includes three additional Missouri counties (Figure 13-4). These additional counties are part of a different payment area that includes the rest of the state. Although they are also in the MSA, their GAF is 7 percent lower than that of the other counties within the Missouri part of the MSA. This is probably because their input prices are being averaged with the less expensive rest of the state.



**Figure 13-4. Counties of the St. Louis Metropolitan Statistical Area (Missouri Part), by Fee Schedule Payment Area**



**SOURCE:** HCFA 1996b.

**NOTES:** The St. Louis metropolitan statistical area (Missouri Part) includes all of the St. Louis payment area and part of another payment area. The other payment area includes the rest of Missouri except the Kansas City area.

GAF is the geographic adjustment factor for a typical service.

In addition to the MSA-related problems within each state, the cross-border relationships seem anomalous. Lincoln County, Missouri, which is a part of the MSA, has a GAF that is 6 percent lower than that of adjacent Calhoun County, Illinois, which is not part of the MSA. Although a detailed analysis might identify the current payment areas for the St. Louis MSA as the ones that best track price variations, minimize border differences, and simplify the payment areas, this is not self evident.

The Commission has recommended using MSAs as the basis for developing payment areas, since they naturally reflect local integrated markets or networks of overlapping markets. HCFA studied and rejected that approach, stating that using the historical areas is less disruptive and does a better job of isolating higher-priced cores of urban areas.

HCFA may be correct that some historical areas accurately identify high-priced urban cores. The new payment area policy does not, however, take full advantage of this feature and continues to perpetuate apparently haphazard subdivisions of many states. A more systematic approach could be based on the principle that counties within an MSA should not be included in the residual rest-of-state payment area if their input prices are heterogeneous or differ from those found elsewhere in the state. Within such MSAs, a method could be devised to separate the highest-priced counties from all others, perhaps based on the one HCFA used for the 1997 revision.

The second problem with HCFA's treatment of MSAs is that the agency's approach analyzes each state separately, not taking into consideration the portion of an MSA that lies in adjacent states.<sup>26</sup> This causes the parts of the MSA to be treated differently, depending on the conditions in the rest of each of the involved states. If input prices are fairly uniform within an MSA, then Medicare's GAFs should be similar as well. HCFA's approach does not guarantee that this will occur.

By not considering border-crossing metropolitan areas as a whole, HCFA risks creating significant payment differentials in populous areas. This has in fact occurred (Table 13-10). Although many state parts of MSAs have similar GAFs, there are some that differ by more than a few percentage points. Ohio and West Virginia, for example, share four metropolitan areas and have statewide GAFs that differ by nearly 7 percent. As previously noted, the mismatches between Illinois and Missouri payment areas and the St. Louis MSA result in adjacent counties with GAFs that differ by more than 7 percent.

**Future Review of Payment Areas.** The use of existing payment areas as building blocks for new ones and the exclusion of statewide areas from analysis can only result in fewer, larger areas over time. That is consistent with HCFA's stated goal of establishing as many statewide areas as possible. Over time, however, demographic and economic changes may occur that would warrant subdividing a payment area into two or more smaller areas. HCFA's approach will prevent it from recognizing when this has occurred, which may lead to inequities in physician payment and beneficiary cost-sharing levels. It may be administratively simpler for HCFA to maintain large payment areas, but this consideration should be secondary to the need to maintain accurate resource-based payment.

The Commission has suggested that payment areas be periodically reviewed and revised to avoid large across-border payment differences and within-border price variation. In its analyses of payment areas, the Commission used county-level data for the entire nation. If HCFA used similar information in the future, the payment areas could reflect any important demographic and economic shifts that may occur.

---

<sup>26</sup> HCFA's approach also overlooks the possible importance of price levels in adjacent out-of-state areas in deciding whether and how to subdivide each state.

**Table 13-10. Border-Crossing Metropolitan Statistical Areas and Their Geographic Adjustment Factors**

Metropolitan Statistical Area	State	Metropolitan Statistical Area Counties	Population (100's)	Geographic Adjustment Factor
Augusta	GA	All	2,758	0.935
	SC	All	1,393	0.915
Boston	MA	Essex	6,701	1.041
		Middlesex	13,985	1.108
		Norfolk	6,161	1.108
		Plymouth	4,353	1.041
		Suffolk	6,639	1.108
	NH	All	2,458	1.003
Charlotte	NC	All	10,305	0.924
	SC	All	1,315	0.915
Chattanooga	GA	All	1,139	0.935
	TN	All	3,104	0.923
Cincinnati	IN	All	441	0.925
	KY	All	3,166	0.921
	OH	All	11,653	0.973
Clarksville	KY	All	689	0.921
	TN	All	1,005	0.923
Columbus	AL	All	469	0.932
	GA	All	2,140	0.935
Cumberland	MD	All	749	0.964
	WV	All	267	0.919
Davenport	IA	All	1,510	0.912
	IL	All	1,999	0.924
Duluth	MN	All	1,982	0.961
	WI	All	418	0.968
Evansville	IN	All	2,360	0.925
	KY	All	430	0.921
Fargo	MN	All	504	0.961
	ND	All	1,029	0.898
Ft. Smith	AR	All	1,421	0.887
	OK	All	338	0.910
Grand Forks	MN	All	325	0.961
	ND	All	707	0.898
Huntington	KY	All	1,122	0.921
	OH	All	618	0.973
	WV	All	1,384	0.919



**Table 13-10.** (continued)

Metropolitan Statistical Area	State	Metropolitan Statistical Area Counties	Population (100's)	Geographic Adjustment Factor
Johnson City	TN	All	3,485	0.923
	VA	All	875	0.944
Kansas City	KS	All	6,050	0.945
	MO	Cass	638	0.911
		Clay	1,534	0.983
		Clinton	166	0.911
		Jackson	6,332	0.983
		Lafayette	311	0.911
		Platte	579	0.983
		Ray	220	0.911
La Crosse	MN	All	185	0.961
	WI	All	979	0.968
Las Vegas	AZ	All	935	0.995
	NV	All	7,593	1.010
Louisville	IN	All	2,031	0.925
	KY	All	7,458	0.921
Memphis	AR	All	499	0.887
	MS	All	679	0.899
	TN	All	8,895	0.923
Minneapolis	MN	All	24,556	0.961
	WI	All	831	0.968
Newburgh	NY	All	3,076	0.973
	PA	All	280	0.951
Norfolk	NC	All	137	0.924
	VA	All	14,294	0.944
Omaha	IA	All	826	0.912
	NE	All	5,569	0.894
Parkersburg	OH	All	623	0.973
	WV	All	869	0.919
Philadelphia	NJ	All	11,933	1.051
	PA	All	37,290	1.066
Portland	OR	Clackamas	2,789	0.981
		Columbia	376	0.933
		Multnomah	5,839	0.981
		Washington	3,116	0.981
		Yamhill	656	0.933
		All	2,381	0.962
	WA	All	2,381	0.962
Portsmouth	ME	All	1,646	0.992
	NH	All	1,042	1.003

**Table 13-10.** (continued)

Metropolitan Statistical Area	State	Metropolitan Statistical Area Counties	Population (100's)	Geographic Adjustment Factor
Providence	MA	All	5,063	1.041
	RI	All	10,035	1.068
Sioux City	IA	All	983	0.912
	NE	All	167	0.894
St. Louis	IL	All	5,889	0.974
	MO	Crawford	192	0.911
		Franklin	806	0.911
		Jefferson	1,714	0.984
		Lincoln	289	0.911
		St. Charles	2,129	0.984
		St. Louis	9,935	0.984
		St. Louis City	3,967	0.984
		Warren	195	0.911
Steubenville	OH	All	803	0.973
	WV	All	622	0.919
Texarkana	AR	All	385	0.887
	TX	All	817	0.924
Washington	DC	District	6,069	1.105
	MD	Calvert	514	0.964
		Charles	1,012	0.964
		Frederick	1,502	0.964
		Montgomery	7,570	1.105
		Prince Georges	7,293	1.105
	VA	Alexandria	1,112	1.105
		Arlington	1,709	1.105
		Clarke	121	0.944
		Culpeper	278	0.944
		Fairfax	8,478	1.105
		Fauquier	487	0.944
		King George	135	0.944
		Loudoun	861	0.944
		Prince William	2,504	0.944
		Spotsylvania	764	0.944
		Stafford	612	0.944
		Warren	261	0.944
	WV	All	952	0.919
Wheeling	OH	All	711	0.973
	WV	All	883	0.919
Wilmington	DE	All	4,419	1.015
	MD	All	713	0.964

SOURCE: 1996 Area Resource File; HCFA 1996b.

## REFERENCES

- American Association of Neurological Surgeons and Congress of Neurological Surgeons, written testimony submitted to the Physician Payment Review Commission, December 11, 1996.
- Cleaveland, Clifton R., American College of Physicians, letter to Bruce C. Vladeck, Health Care Financing Administration, February 6, 1995.
- DeHaven, Kenneth E., American Academy of Orthopaedic Surgeons, written testimony submitted to the Physician Payment Review Commission, November 13, 1996.
- Doherty, Robert B., American Society of Internal Medicine, written testimony submitted to the Physician Payment Review Commission, February 11, 1997.
- Dunn, Daniel L. and Eric Latimer, *Derivation of Relative Values for Practice Expense Using Extant Data*, report to the Health Care Financing Administration under Contract No. 500-92-0023, April 1, 1996.
- Health Care Financing Administration, Department of Health and Human Services, "Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule; Notice," *Federal Register* 61(87):19992-20067, May 3, 1996a.
- Health Care Financing Administration, Department of Health and Human Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1997; Proposed Rule," *Federal Register* 61(128):34614-34662, July 2, 1996b.
- Health Care Financing Administration, Department of Health and Human Services, "Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1997; Final Rule," *Federal Register* 61(227):59490-59716, November 22, 1996c.
- Health Economics Research, Inc., *Assessment and Redesign of Medicare Fee Schedule Areas (Localities)*, report to the Health Care Financing Administration under Contract No. 500-92-0020, November 1995.
- Levy, Jesse, Office of Research and Demonstrations, Health Care Financing Administration, personal communications to the Physician Payment Review Commission, 1996.
- Physician Payment Review Commission, *Annual Report to Congress 1990* (Washington, DC: 1990).
- Physician Payment Review Commission, *Annual Report to Congress 1991* (Washington, DC: 1991).



Physician Payment Review Commission, *Annual Report to Congress 1992* (Washington, DC: 1992a).

Physician Payment Review Commission, *Practice Expenses Under the Medicare Fee Schedule: A Resource-based Approach*, No. 92-1 (Washington, DC: 1992b).

Physician Payment Review Commission, *Annual Report to Congress 1993* (Washington, DC: 1993).

Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).

Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).

Pope, Gregory C., and Russel T. Burge, *Derivation of Relative Values for Practice Expense Using Extant Data*, report to the Health Care Financing Administration under Contract No. 500-92-0020, May 20, 1996.

Practice Expense Coalition, written testimony submitted to the Physician Payment Review Commission, December 11, 1996.

Seward, John P., American Medical Association, letter to the Physician Payment Review Commission, February 20, 1997.



# Access and Beneficiary Financial Liability under the Medicare Fee Schedule

Important changes in Medicare physician payment policy were enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). The law included provisions to establish the Medicare Fee Schedule which, when implemented in 1992, restructured payments across services, specialties, and geographic areas. OBRA89 also put in place a Volume Performance Standard (VPS) system to constrain growth in expenditures for physicians' services, and limits on physicians' charges to strengthen beneficiary financial protection. Such policy changes have the potential to influence beneficiary access to care and financial liability. For this reason, the Congress called for the Secretary of Health and Human Services and the Physician Payment Review Commission to monitor implementation of the program and recommend measures to address any problems with beneficiary access or financial protection that are identified.

In fulfilling this congressional mandate, the Commission has adopted a strategy that captures many of the dimensions of access that shape beneficiaries' experiences in obtaining care. Access monitoring must encompass the perspectives of both beneficiaries and physicians. To do so requires use of data from multiple sources, since no single data set can fully address all aspects of access to care. Medicare claims data can show changes in beneficiary use of services. Clinically based indicators of access allow the Commission to examine beneficiary use of specific services considered necessary for the care of different acute and chronic conditions. Data from the

*This chapter includes:*

- *Analyses of beneficiary service use*
- *Analyses of access as reported by beneficiaries*
- *Analyses of access problems of vulnerable beneficiaries*
- *New information on beneficiary financial liability*



Medicare Current Beneficiary Survey (MCBS) reveal whether beneficiaries report problems obtaining care or have become less satisfied with the care received. Gathering data on beneficiary complaints about access to physicians can complement the MCBS data. Both physician surveys and claims data can be used to assess physician willingness to serve Medicare beneficiaries. Over the years, the Commission has analyzed data from these varied sources to provide the Congress with an assessment of how Medicare beneficiaries are faring under the policies adopted in OBRA89 and modified since that time.

A key element in the Commission's monitoring strategy has been to focus on access for vulnerable groups of beneficiaries. These groups, such as African Americans and those living in poverty areas and in Health Professional Shortage Areas (HPSAs), are believed to be more likely to experience access problems related to payment policy changes. Historically, much of the research on access for vulnerable groups, including that of the Commission, has been descriptive in nature, focusing on differences in access between these groups and others. The Commission's recent work has addressed the underlying reasons for those problems, such as differences in income, supplemental insurance coverage, and health status.

Since it began its monitoring efforts, the Commission has found consistently that access has remained good for most beneficiaries. Any decreases seen in use of selected services since the fee schedule was introduced appear related not to changes in payment rates but, rather, to changes in treatment modalities and other factors unrelated to access. Beneficiaries report no increases in problems obtaining care and their satisfaction with care continues to be high.

Despite these generally positive findings on access, the Commission is concerned that some vulnerable groups, including African Americans, continue to experience access problems that existed prior to 1992. These groups use fewer primary care services than others and visit emergency rooms more often than others. In surveys, they report more problems obtaining care and lower satisfaction with care.

With respect to beneficiary financial liability, OBRA89's charge limit is constraining the additional amounts physicians bill beneficiaries. Charges above the limit have declined since 1992. Commission analyses have shown that most charges exceeding the limit do so by relatively small amounts.

The full implementation of the Medicare Fee Schedule does not diminish the need for monitoring. Further developments in both Medicare and the broader health care market will continue to affect beneficiaries. For example, flaws in the current VPS system could result in substantial reductions in payments to physicians (see Chapter 12). Proposed changes in the VPS policy to correct these flaws could have differential effects on physicians depending on the mix of services they provide. Other policy changes, such as implementation of resource-based practice expense relative values, scheduled for 1998, will reduce payments for some services while increasing payments for others (see Chapter 13). Finally, changes in the market for health services, such as the growth of managed care, could affect the cost and availability of care under Medicare fee for service as well.

The Commission's mandated reports on access and financial liability will be submitted to the Congress in May. This chapter previews analyses to be presented in those reports. The first section updates the Commission's earlier work on beneficiary access using Medicare claims data and data from the Medicare Current Beneficiary Survey. It also presents an analysis of factors contributing to the access problems of vulnerable groups of beneficiaries. The chapter then turns to issues of beneficiary financial liability for physicians' services, updating information on assignment rates and the percentage of physicians participating in Medicare. In addition, this year the Commission has broadened its examination of beneficiary financial liability to include information on beneficiary out-of-pocket spending for other services in addition to physicians' services. Plans for additional work to be included in the Commission's mandated reports are discussed in both sections of the chapter.

## **ACCESS TO CARE**

Analyses of Medicare claims data and responses to the Medicare Current Beneficiary Survey allow the Commission to assess service use and beneficiaries' experiences in obtaining care. These Medicare program data are updated each year.

### **Changes in Beneficiary Use of Services**

Growth in beneficiary use of services was relatively modest in 1996. The volume and intensity of all services per beneficiary rose at a rate of 1.0 percent between 1995 and 1996 (Table 14-1).<sup>1</sup>

The low volume growth in 1996 may be part of a trend that emerged in the early 1990s. Before 1992, volume growth was volatile. During the 10 years ending in 1991, the annual rate of volume growth ranged from 3.7 percent to 10.0 percent. Volume growth was low for two consecutive years only once during that period, in 1984 and 1985 (PPRC 1996). By contrast, volume growth has been low—5 percent or less—every year since 1992.

Claims data do not reveal changes in beneficiary access to care that are clearly related to changes in Medicare's physician payment rates (Table 14-1). Between 1995 and 1996, some services with payment rate decreases also experienced a fall-off in volume (e.g., outpatient visits and electrocardiograms), while for others the volume increased (e.g., cataract lens replacements and echocardiograms). Evidence of a possible relationship between lower Medicare payment rates and a decline in beneficiary use of services would prompt further analysis by the Commission.<sup>2</sup>

---

<sup>1</sup> Two limitations of the claims data should be considered when interpreting these results. First, the claims files are incomplete since they include only those claims processed by September of each year, or three months beyond the half-years under study. Second, analysis of a 5 percent sample of claims means the payment rate and service use measures presented are subject to sampling error. Further details on the Commission's analyses of Medicare claims data are provided in *Monitoring Access of Medicare Beneficiaries* (PPRC 1995).

<sup>2</sup> Further analysis of the relationship between payment rates and use of services would require consideration of factors other than payment rates which may influence use of services. Those factors include health system characteristics, such as physician supply and improvements in medical technology, as well as beneficiary characteristics, such as health status and supplemental insurance coverage.

**Table 14-1. Change in Payment and Use per Beneficiary for Selected Services, 1992-1996 (percentage)**

Type of Service	Annual Percentage Change						Percentage of 1996 Physician Services Outlays
	1992-1995			1995-1996			
	Payment per Service	Volume <sup>a</sup>	Count of Services <sup>b</sup>	Payment per Service	Volume <sup>a</sup>	Count of Services <sup>b</sup>	
All Services	2.8	4.1	3.8	-2.2	1.0	-2.0	100.0
Primary Care Services	6.9	4.1	3.3	0.7	1.7	0.7	22.8
Office and other outpatient visits	6.2	3.0	2.7	-1.2	-0.7	-1.9	16.3
Emergency department visits	9.0	9.3	7.5	0.4	2.4	1.9	2.6
Nursing facility/rest home visits	10.8	7.6	6.0	1.4	6.5	5.4	2.1
Home visits	10.7	4.5	3.9	3.1	4.8	3.8	0.2
Other Evaluation and Management Services	5.4	5.0	2.5	1.9	0.5	-1.8	18.2
Surgical Services	2.8	2.3	5.7	-5.0	2.5	3.6	21.6
Cataract lens replacement	-1.1	-1.3	-1.3	-15.5	0.9	0.9	2.9
Joint prosthesis	2.2	5.0	4.5	-4.8	2.4	2.5	1.4
Coronary artery bypass graft	2.6	5.4	6.3	-3.1	4.5	5.7	1.4
Transurethral prostate surgery	5.6	-12.1	-11.8	0.5	-9.3	-8.4	0.3
Arthroscopy	1.6	7.5	7.3	-7.2	0.3	-0.1	0.2
Open prostate surgery	5.0	-15.5	-14.9	0.5	7.3	5.5	0.1
Other Nonsurgical Services	-0.2	4.8	4.0	-4.1	0.0	-3.4	37.4
Diagnostic radiology, other	0.2	0.4	0.8	-3.1	-0.8	-2.4	3.1
Electrocardiograms	— <sup>c</sup>	— <sup>c</sup>	— <sup>c</sup>	-2.7	-2.7	-5.7	2.0
Echocardiograms	-5.1	13.3	13.7	-15.2	13.2	25.3	1.8
CAT scans	-0.1	3.0	4.1	-3.8	6.2	6.0	1.6
Colorectal endoscopy	-0.8	2.3	-2.3	-5.0	2.0	-0.5	1.4
Magnetic resonance imaging	1.6	10.9	11.3	-1.2	11.3	10.7	1.1
Upper GI endoscopy	-4.2	3.8	2.5	-10.3	1.5	0.7	0.9
Angioplasty	-6.5	10.5	10.4	-10.4	8.5	5.2	0.6
Mammography	1.1	-1.7	0.8	-0.5	-3.2	-1.5	0.4

SOURCE: Physician Payment Review Commission analysis of 1992-1996 Medicare claims, 5 percent sample of beneficiaries.

<sup>a</sup> Measures change in outlays if prices were frozen (number and intensity of services).

<sup>b</sup> Measures change in the number of services only.

<sup>c</sup> Not applicable due to payment change.

NOTE: Data are for the first six months of each year.

The use of some services decreased between 1995 and 1996 (Table 14-1). The volume of transurethral prostate surgery dropped by 9.3 percent, and the volume of mammography fell by 3.2 percent. Other services with volume decreases are office and other outpatient visits (-0.7 percent), routine diagnostic radiology (-0.8 percent), and electrocardiograms (-2.7 percent).



Reductions in the use of transurethral prostate surgery do not appear to be related to access to care. Such reductions have occurred in previous years and appear to be part of changes in treatment modalities for prostate disease (PPRC 1996).

In the case of mammography, the Commission has found that less than 40 percent of female Medicare beneficiaries receive a mammogram every two years (PPRC 1995). Claims data show that mammography volume growth was 20 percent from 1990 to 1991, the first year that Medicare coverage was extended to include screening mammography.<sup>3</sup> Since then, mammography volume growth has been low, suggesting that awareness of the screening benefit may not have increased after its initial announcement.

Other declines in service use—office visits, routine diagnostic radiology, and electrocardiograms—are more difficult to explain. In an environment where practice patterns are changing, because of managed care and other influences, some decreases in volume may not be surprising. The decreases could be the result of improved efficiency in the delivery of services, or they could involve reductions in the use of needed services.

Because of the uncertainty about the cause of some volume decreases, the Commission will examine the affected services further in its upcoming access report. Some of this work will assess whether use of needed services has decreased. The Commission will use clinically based indicators of access, developed by RAND, for this analysis (PPRC 1995). These indicators will not provide a comprehensive assessment of why the volume of selected services decreased. They can show, however, whether certain services that experienced an overall decline in use also declined in relation to specific conditions for which they are considered necessary. Other work will consider decreases in use of services by geographic area to explore the relationship between health care market characteristics and changes in the volume of services.

### **Access As Reported by Beneficiaries**

The Commission's analyses of beneficiary reports about their access to care have been updated with data from the 1995 MCBS. The MCBS provides information on specific aspects of beneficiary access to care, such as difficulty in finding a physician, delays in seeking care, availability of a usual source of care, and satisfaction with care.

**Access for All Beneficiaries.** Responses to MCBS questions were used to construct eight measures of access to care. Four of these measures address the process of care: whether a beneficiary (1) had trouble getting care, (2) had a problem but did not see a physician, (3) delayed care due to cost, or

---

<sup>3</sup> Previously, Medicare covered only diagnostic mammography.

(4) did not have a physician or physicians' office as a usual source of care.<sup>4</sup> Four other measures address nonclinical outcomes of care: (1) strong agreement with the statement "physician checks everything," (2) strong agreement with the statement "great confidence in physician," (3) very satisfied with availability of medical care at night and on weekends, and (4) very satisfied with overall quality of care. All these measures are believed to be sensitive to changes in access but can be influenced by other factors, such as the quality of care received.

Data from the 1995 MCBS show that access for most beneficiaries remains excellent and that measures of access are essentially unchanged from previous years. Among all beneficiaries, about 4 percent had trouble getting care, and 10 percent to 12 percent either had a problem but did not see a physician, delayed care due to cost, or were without a physician or physician's office as a usual source of care (Table 14-2). Measures of nonclinical outcomes (e.g., very satisfied with the availability of care) from the 1995 MCBS also show little change from previous years. Of the respondents, 26 percent strongly agreed with the statement that their physician checks everything; 27 percent reported great confidence in their physician (Table 14-3). About 21 percent said they are very satisfied with the availability of medical care, and 33 percent are very satisfied with the overall quality of care (Table 14-3).<sup>5</sup>

**Access for Vulnerable Groups.** Data from the 1995 MCBS show essentially no change in the access problems reported by some vulnerable groups in earlier rounds of the MCBS. Nonwhite and Hispanic beneficiaries, and those with no supplemental insurance, reported more trouble getting care (Table 14-2).<sup>6</sup> The functionally disabled, who require help with activities of daily living, were also more likely to have trouble getting care. Each of these groups was also more likely to have delayed care because of cost. Nonwhite and Hispanic beneficiaries, and those without supplemental insurance, were also less likely to have a physician or physician's office as a usual source of care.

Distinctions among groups were also found in their responses to questions on nonclinical outcomes, such as satisfaction with the availability of care (Table 14-3). Compared with their counterparts, four groups—nonwhite beneficiaries, those needing help with activities of daily living, those over the age of

---

<sup>4</sup> Over the successive annual rounds of the MCBS, similar percentages of beneficiaries have indicated they have "had a problem but did not see a physician." This measure is influenced both by the extent to which beneficiaries have health problems and by the extent to which they do or do not see a physician. For access monitoring, the extent to which beneficiaries see a physician is more important, but the structure of the MCBS does not permit separation of the two influences. Because of the measure's stability, this limitation of the MCBS does not seem important. If the measure does change, the Commission will attempt to determine whether the change is due to the extent to which beneficiaries are seeing a physician when they have a health problem.

<sup>5</sup> Analyses of nonclinical outcomes distinguish those respondents who are "very satisfied" or "strongly agree" from all others. This approach conforms with concerns noted by Ware (1995) about collapsing categories in ordered scales, such as "very satisfied" and "satisfied." Collapsing categorical responses to survey questions masks important differences among perceptions of health care outcomes.

<sup>6</sup> Within Hispanic populations, access to care may vary depending on a person's ethnic origin (Schur et al. 1987). Since MCBS respondents designating themselves as Hispanic are not asked about ethnic origin, the analysis does not address these subgroups.

possible explanations for these differences; that is, access may be affected by other factors, which could not be addressed in this analysis. These include other aspects of the availability and organization of services; personal preferences and behaviors of beneficiaries; unmeasured dimensions of health status, including genetic and environmental factors; and racial discrimination (Geiger 1996; Escarce et al. 1993).

This analysis was designed to aid development of options for solving the access problems of vulnerable groups. Not surprisingly, it has shown that solving those problems will be difficult. Multiple factors are important, and some of them, such as health status and supplemental insurance coverage, are only indirectly related to Medicare payment policy.

In the past, the Commission has recommended that multiple approaches should be considered to maintain and expand service delivery for underserved Medicare beneficiaries (PPRC 1995). Among those approaches are ensuring appropriate numbers and distribution of health professionals; changing payment policy; and making certain beneficiaries have access to new health care delivery systems. The analysis presented above reaffirms the importance of a broad-based strategy to improve access for vulnerable beneficiaries.

## **BENEFICIARY OUT-OF-POCKET SPENDING**

A number of policies under Medicare fee for service are intended to protect beneficiaries from excessive out-of-pocket expenses for physicians' services. Providers are encouraged to bill on assignment, meaning that they accept the Medicare payment amount as full compensation and receive payment directly from Medicare. The Participating Physician and Supplier (PAR) program provides incentives for physicians to accept all of their claims in this manner. For example, payment under the Medicare Fee Schedule is 5 percent higher for participating physicians than for nonparticipating physicians. In addition, participating physicians are provided with toll-free lines if they submit claims electronically, and their names are included in the Medicare Participating Physician/Supplier Directory.

A form of beneficiary protection also exists for claims that are not assigned. OBRA89 specifies percentage limits on the amount that physicians can bill beneficiaries above Medicare's payment amount. The limits are 115 percent of nonparticipating physician payment rates, or 109.25 percent (115 percent of 95 percent) of Medicare Fee Schedule payment rates.

Together, these policies leave Medicare beneficiaries responsible for a \$100 deductible, coinsurance of 20 percent of the Medicare Fee Schedule payment amount, and additional charges (balance bills) of at most 15 percent of the Medicare payment for physicians' services provided on a fee-for-service basis.<sup>11</sup>

---

<sup>11</sup> Most beneficiaries (about 87 percent) have some form of supplemental insurance policies that cover all or most of these cost-sharing expenses (see Chapter 15).



Each year, the Commission reports on beneficiary financial liability in the context of out-of-pocket spending for physicians' services. The Commission has consistently found that the physician payment reforms included in OBRA89 have successfully constrained balance billing and increasing numbers of physicians are accepting Medicare-allowed charges as payment in full.

To get a more complete picture of beneficiary financial liability, this year, the Commission has expanded its focus to examine beneficiaries' overall out-of-pocket costs related to health care. Those costs include Part B premiums (\$43.80 per month); Part A and Part B annual deductibles (\$100 and \$760, respectively); Part A and Part B copayments; and balance bills. These are in addition to expenses they may incur for supplemental health insurance premiums and services not covered by Medicare. Medicare does not place any limits on overall out-of-pocket spending.

This section includes information describing beneficiaries' out-of-pocket health care expenditures, including cost sharing for Medicare-covered services, balance billing from Part B providers, cost of noncovered services, and Medicare Part B and private health insurance premiums. It also updates information on assignment of claims, the PAR program, and balance billing.

### **Total Out-of-Pocket Spending**

Elderly Americans spend nearly four times more out of pocket for health care than those under 65 (AARP 1995). Noninstitutionalized Medicare beneficiaries, on average, spent \$2,605 for health care in 1996 (Moon et al. 1996).<sup>12</sup> Currently, out-of-pocket spending represents 21 percent of household income for the elderly overall. The proportion of income the elderly devote to health care spending has risen over the years. In 1987, they spent about 15 percent of their incomes on health-related services. The elderly poor and near-poor spend an even greater percentage of their income on health care services than those in wealthier groups. For example, those with incomes below 125 percent of the poverty level spend roughly 30 percent of family income on out-of-pocket health care costs (Figure 14-6) (Moon et al. 1996).

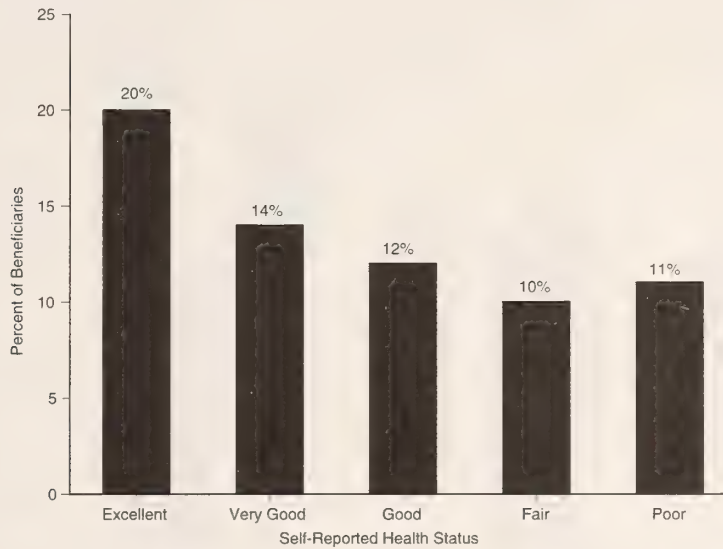
The oldest and the sickest beneficiaries are at the greatest risk for high out-of-pocket spending. Cost-sharing burdens are highly concentrated among the most severely ill. For example, in 1996, Medicare-related out-of-pocket spending for the sickest 10 percent of the Medicare population was roughly \$5,600 per beneficiary, while the healthiest 20 percent had no cost-sharing expenses (Moon et al. 1996).

Out-of-pocket spending on health care also differs across age groups, with the proportion of family income devoted to health care costs increasing with age. While those aged 65 to 69 spend about

---

<sup>12</sup> This includes cost sharing for Medicare-covered and noncovered services and products, Medicare Part B premiums, private health insurance premiums, and balance billing. Noninstitutionalized beneficiaries represent 86 percent of the total Medicare population. Cost sharing is considerably higher for institutionalized beneficiaries (Moon et al. 1996).

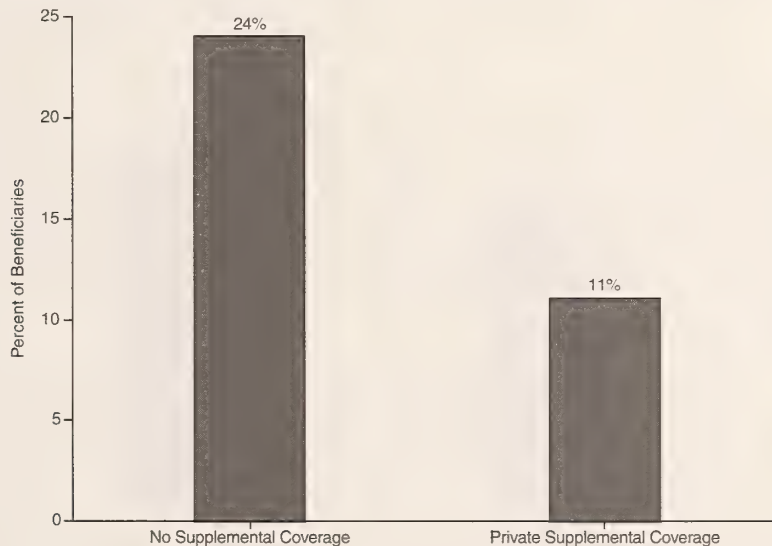
**Figure 14-2. Beneficiaries with No Usual Source of Care, by Health Status (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

**NOTE:** Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

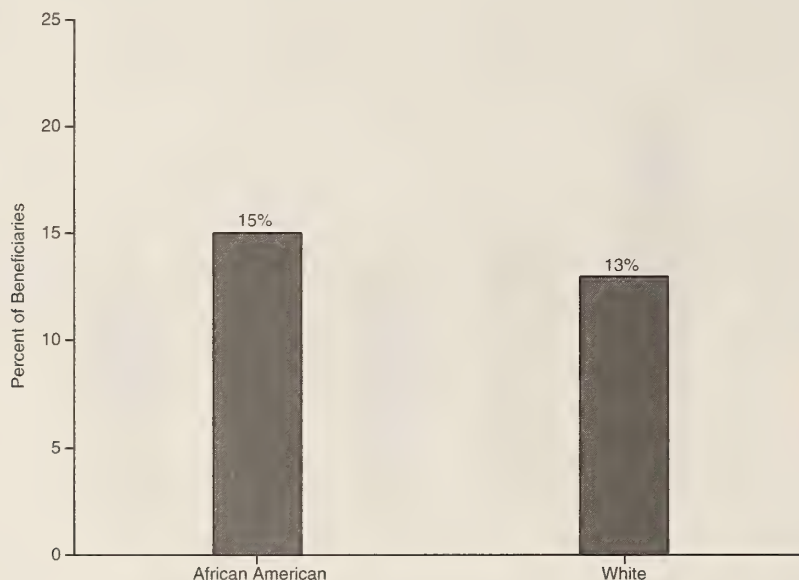
**Figure 14-3. Beneficiaries with No Usual Source of Care, by Supplemental Coverage (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

**NOTE:** Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

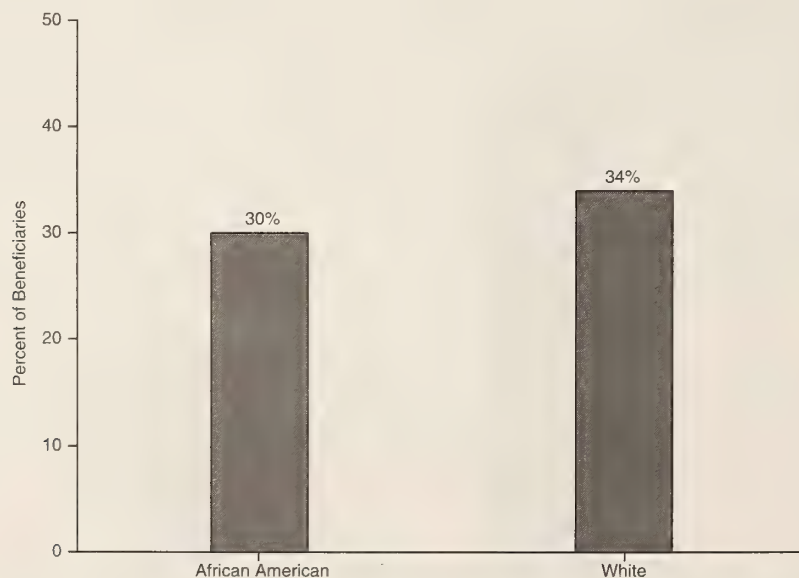
**Figure 14-4. Beneficiaries with No Usual Source of Care, by Race (percentage)**



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

**Figure 14-5. Beneficiaries Very Satisfied with Overall Quality of Care, by Race (percentage)**

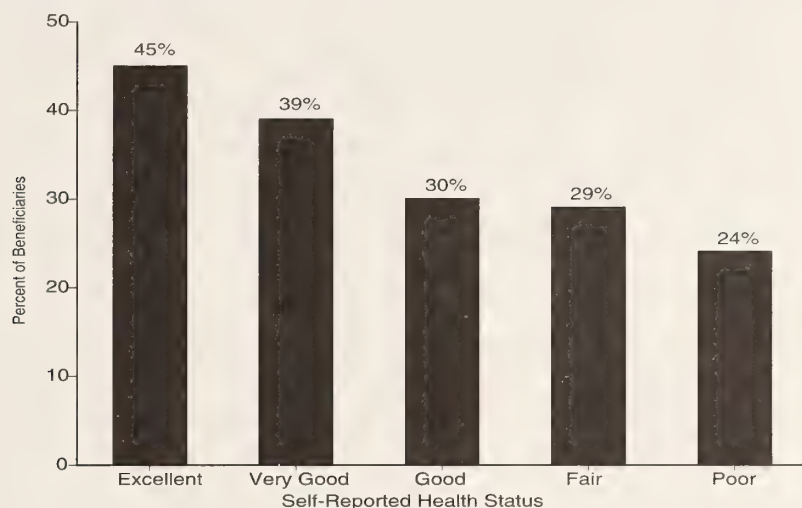


SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.



**Figure 14-1. Beneficiaries Who Are Very Satisfied with Overall Quality of Care, by Health Status (percentage)**



**SOURCE:** Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

**NOTE:** Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

explanatory variables described characteristics of beneficiaries, such as age, sex, race, and self-reported health status. Residence in a HPSA described the health system available to beneficiaries.<sup>7</sup> Other variables captured a combination of personal and health system characteristics, such as secondary insurance coverage. Dependent variables in the analysis (measures of access to care) included the eight process and nonclinical outcomes measures used in the MCBS analysis described above.<sup>8</sup>

This analysis is limited by the set of variables available from the MCBS. Some important factors—such as health behaviors and attitudes, better measures of health status, and some aspects of the availability of services—are not addressed by the MCBS. Other measures, including clinically oriented outcomes of care and the use of high-tech services, could not be included in the analysis because the sample size was too small. Nonetheless, the MCBS does allow analysis of a number of important factors believed to influence access to care.

**Results.** Several factors help explain variation in measures of beneficiary access to care. Self-reported health status appears to have an important influence on access, controlling for other beneficiary and health system characteristics (Figure 14-1). Those reporting poorer health status also cite more access

---

<sup>7</sup> Alternative regression models were estimated using a physician-to-population ratio, based on county-level data from the Area Resource File, as a measure of the availability of services. The ZIP code-specific HPSA variable was found to have a stronger statistical relationship with the access measures than the county-level physician-to-population ratio.

<sup>8</sup> Since the dependent variables had a value of either zero or one, logistic regression models were estimated. The models were estimated with SUDAAN software, which corrected the standard errors of the estimates for the nonrandom design of the MCBS.

problems than others and lower satisfaction with the care received. For example, 45 percent of those reporting excellent health also report being very satisfied with the overall quality of care. Only 24 percent of those reporting poor health are very satisfied with the overall quality of care. Those saying they are in excellent health are more likely than those in poor health to be without a physician or physicians' office as a usual source of care. About 20 percent of those reporting excellent health report no physician or physicians' office as a usual source of care, whereas only 11 percent of those citing poor health report the same problem (Figure 14-2). Those reporting poor health may be more likely to have a physician or physician's office as a usual source of care owing to their greater need for care.

A marker of vulnerability, the lack of supplemental insurance coverage, is another factor associated with variation in beneficiary access to care, controlling for other beneficiary and health system characteristics. Findings with respect to two of the eight access measures—no physician or physician's office as a usual source of care and satisfaction with the overall quality of care—are illustrative. Among those without supplemental insurance, 24 percent report not having a physician or physician's office as a usual source of care compared with 11 percent of those with private supplemental coverage (Figure 14-3). Supplemental insurance coverage was not significantly related to satisfaction with the overall quality of care in this analysis.

Race also helps explain variation in beneficiary access. Compared with whites, more African-American beneficiaries are without a physician or physician's office as a usual source of care. The difference between the two groups is small, however (Figure 14-4). Fewer African-American beneficiaries are very satisfied with the overall quality of care (30 percent) compared with white beneficiaries (34 percent) (Figure 14-5). These differences are smaller than those presented earlier in this chapter (Tables 14-2 and 14-3). The results presented earlier were not adjusted for beneficiary and health system characteristics.

**Conclusions.** Some tentative conclusions are possible. Several factors help explain variation in measures of beneficiary access to care. Chief among these appears to be health status. Those reporting poorer health status also report more access problems than others and lower satisfaction with the care received.<sup>9</sup> Supplemental insurance coverage is another factor that appears to be related to process-oriented measures of access, such as not having a physician or physician's office as a usual source of care, but supplemental insurance does not seem to be related to satisfaction.

After adjusting for certain personal and health system characteristics, some differences in access between African-American and white beneficiaries remain unexplained.<sup>10</sup> There are a number of

---

<sup>9</sup> These fee-for-service enrollee findings are consistent with the findings of a Commission-sponsored survey of Medicare managed-care enrollees (Nelson et al. 1996).

<sup>10</sup> Other differences in access between African-American and white beneficiaries, not addressed in this analysis, could be important and deserve further research. For example, African American beneficiaries are less likely to have supplemental insurance coverage than white beneficiaries (Chulis et al. 1993). Some of the association between supplemental insurance coverage and access, found in this analysis, could be a combination of the effect of race on supplemental coverage and the effect of supplemental coverage on access.

**Table 14-2. Medicare Beneficiaries Reporting Problems with Access, 1995 (percentage)**

Population Group	Had Trouble Getting Care	Had Problem, But Did Not See a Physician	Delayed Care Due to Cost	No Usual Source of Care <sup>a</sup>
All Beneficiaries	4	11	10	12
Race				
African American	5	14	12	19
White	3	10	9	11
Other	7	14	12	25
Ethnicity				
Hispanic	<sup>b</sup>	<sup>b</sup>	14	27
Other	<sup>b</sup>	<sup>b</sup>	9	11
Functional Disability				
Help needed	8	17	15	9
No help needed	3	10	9	13
Age				
85 years and over	<sup>b</sup>	7	5	7
Under 85	<sup>b</sup>	11	10	12
Supplemental Insurance <sup>c</sup>				
No	9	19	24	27
Yes	3	10	8	10

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

<sup>a</sup> Defined as not identifying a physician's office or a particular physician as a usual source of care.

<sup>b</sup> No statistically significant difference between population groups at the 5 percent level.

<sup>c</sup> Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

85, and those without supplemental insurance coverage—were less satisfied with the quality of their care. African Americans and Hispanics were also less apt to agree with statements that they had great confidence in their physician or that their physician checks everything. African Americans and those without supplemental insurance were less likely to be very satisfied with the availability of medical care.

### Factors Related to the Access Problems of Vulnerable Groups

The Commission's analyses of Medicare claims and enrollment data have also shown that some groups of beneficiaries, such as African Americans and those living in urban poverty areas and urban Health Professional Shortage Areas, use fewer primary care services and make more visits to emergency rooms and hospital outpatient departments than others. Health outcomes, measured by mortality rates and other indicators, are often poorer for these groups (PPRC 1993; PPRC 1995; PPRC 1996).



**Table 14-3. Medicare Beneficiaries' Attitudes Toward the Care They Receive, 1995**  
(percentage)

Population Group	Strongly Agree with "Physician Checks Everything"	Strongly Agree with "Great Confidence in Physician"	Very Satisfied with Availability of Medical Care	Very Satisfied with Overall Quality of Care
All Beneficiaries	26	27	21	33
Race				
African American	19	20	10	20
White	27	28	22	35
Other	28	27	21	24
Ethnicity				
Hispanic	33	a	a	a
Other	26	a	a	a
Functional Disability				
Help needed	23	a	18	29
No help needed	27	a	21	34
Age				
85 years and over	23	24	21	28
Under 85	27	27	18	34
Supplemental Insurance <sup>b</sup>				
No	22	22	16	25
Yes	27	28	21	34

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

<sup>a</sup> No statistically significant difference between population groups at the 5 percent level.

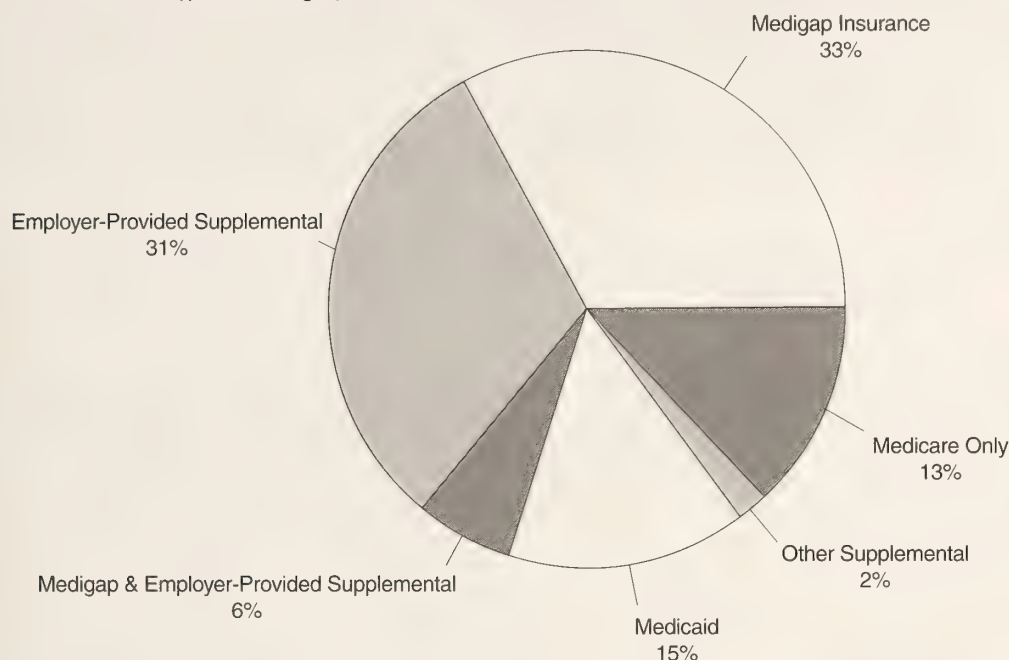
<sup>b</sup> Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

This year, the Commission sought to move beyond describing the access problems of vulnerable groups to identifying factors contributing to those problems. Such analyses are meant to show whether there are factors that could be influenced by Medicare payment policy. Previous research has shown that access is related, in part, to personal characteristics, such as age, income, and education, of those needing care (Aday and Andersen 1981; Weissman and Epstein 1994). Characteristics of the health care system, such as the availability and organization of services, have also been shown to be associated with access (Aday and Andersen 1981; Weissman and Epstein 1994). It is in this second area where payment policy may play a role.

**Methods.** To analyze factors related to the access problems of vulnerable groups of Medicare beneficiaries, regression analyses were conducted using data from the 1994 MCBS. The analyses allowed the estimation of independent statistical relationships between explanatory variables, measuring beneficiary and health system characteristics, and various measures of access to care. Some

**Figure 15-1. Supplemental Insurance Status of Beneficiaries in Medicare Fee for Service, 1995 (percentage)**



SOURCE: Physician Payment Review Commission analysis of the 1995 Medicare Current Beneficiary Survey.

## INDIVIDUAL MEDIGAP INSURANCE

Medigap insurance generally provides almost total coverage of all Medicare deductible and coinsurance requirements. The typical premium for a community-rated Medigap plan is expected to be about \$1,300 in 1997 (Prudential 1997b).

The Omnibus Budget Reconciliation Act of 1990 (OBRA90) (P.L. 101-508) simplified supplemental insurance, limited Medigap policies to 10 standard plans, and established federal minimum standards for such policies. Formerly, insurers could offer any benefits or combinations thereof, and no uniform standards governed the marketing, sale, or financial performance of Medigap plans. Although beneficiaries may renew pre-OBRA90 plans, policies issued after July 31, 1992, must be 1 of the 10 standard plans.<sup>3</sup> Insurance experts estimate that roughly half of Medicare beneficiaries with Medigap coverage still hold non-standard supplemental plans.

---

<sup>3</sup> Massachusetts, Minnesota, and Wisconsin have waivers of the standardization requirements because they already had standardization requirements in place when OBRA90 was enacted. For more information on the requirements of OBRA90 and other legislation related to Medigap insurance, see Chapter 16 in the Commission's *Annual Report to Congress 1996* (PPRC 1996).

The benefits covered by the 10 standard Medigap plans (Plans A-J) range from a basic core benefits package to more comprehensive policies. The basic policy covers Medicare Parts A and B coinsurance, additional hospital days, and blood products. The more generous plans cover additional benefits like skilled nursing facility coinsurance, Medicare deductibles, balance bills, prescription drugs, or preventive medical care (Table 15-1). Under OBRA90, states may further limit the number of plans, but the core benefits plan (Plan A) must always be available and offered by all insurers selling any Medigap policies.

**Table 15-1. Benefits Covered under Standard Medigap Policies and Sales Distribution of Different Plans**

Covered Benefits	Standard Medigap Plans									
	A	B	C	D	E	F	G	H	I	J
Core Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B Deductible			✓			✓				✓
Part B Excess Charges						✓	<sup>a</sup>		✓	✓
Prescription Drugs								<sup>b</sup>	<sup>b</sup>	<sup>c</sup>
Preventive Medical Care					✓					✓
Distribution of Sales <sup>d</sup>	7.0%	16.3%	22.0%	4.4%	1.2%	32.7%	2.3%	6.0%	3.3%	4.8%

SOURCE: National Association of Insurance Commissioners' Model Regulation 1995 and Fox et al. 1995.

<sup>a</sup> Medigap policy pays 80 percent of balance billing charges.

<sup>b</sup> After a \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$1,250.

<sup>c</sup> After a \$250 deductible, the policy covers 50 percent of prescription drug costs to a maximum of \$3,000.

<sup>d</sup> This distribution is derived from the results of a 1992-1993 survey of insurance carriers.

NOTE: Core benefits include Part A copayment for days 61-90 in the hospital, Part A copayment for each lifetime reserve day in the hospital, up to 365 additional days of hospital coverage after Medicare coverage is depleted, the first three pints of blood used under Part A or Part B, and the 20 percent coinsurance for Part B services after the Part B deductible has been met.

Among beneficiaries with standard Medigap policies, 93 percent have coverage for the core benefits package and at least the Part A deductible. More than 50 percent purchase either Plan C or Plan F, both of which cover the core benefits package, the Part A and Part B deductibles, skilled nursing facility coinsurance, and foreign travel emergencies. Only 14 percent of beneficiaries have Medigap insurance that covers any prescription drugs (Table 15-1) (Fox et al. 1995).



# Private Secondary Insurance for Medicare Beneficiaries

Nearly 9 out of 10 Medicare beneficiaries hold some form of supplemental insurance to augment their Medicare coverage. This insurance comes in three basic forms: individually purchased Medigap insurance, employer-provided retiree health benefits, and Medicaid.

Secondary insurance covers some items, services, and cost sharing that Medicare does not, including deductibles, coinsurance, and balance bills. Such insurance provides valuable financial protection to Medicare beneficiaries and is associated with better access to care for those beneficiaries who have it. It also imposes costs on the Medicare program. Medicare's cost-sharing provisions are intended, in part, to encourage beneficiaries to be more cost-conscious in their use of health care services. By insulating beneficiaries from these costs, secondary insurance counteracts such incentives, driving up utilization and Medicare spending.

Aside from its implications for Medicare spending and policymakers' ability to reform the Medicare program, secondary insurance raises three distinct policy issues. First, different rules and underwriting standards for Medigap and Medicare risk plans may create barriers for beneficiaries wishing to move among Medicare coverage options. These barriers, in turn, may lead some beneficiaries to purchase duplicative supplemental insurance. Second, employers' increasing use of managed-care plans to provide supplemental benefits to their Medicare-eligible retirees presents opportunities and challenges for integrating retirees' coverage. Finally, the lack of comprehensive data on beneficiaries' secondary insurance status complicates evaluations of policy changes affecting secondary insurance and makes it difficult to

*This chapter includes:*

- *Profiles of Medigap and employer-provided secondary insurance*
- *The effect of supplemental insurance on Medicare expenditures*
- *A description of portability and the issues it raises in the secondary insurance market*
- *A recommendation on data reporting requirements for providers of supplemental insurance*

predict the effects of this insurance on Medicare reform efforts. In response to this need—and in light of the Health Care Financing Administration's (HCFA) plans to implement a new data and administrative system for the Medicare program—the Physician Payment Review Commission recommends mandatory reporting of beneficiaries' supplemental insurance status.

## *Recommendation*

*Insurers and employers that provide insurance which supplements basic Medicare benefits should be required to report information about beneficiaries' purchase or receipt of such insurance to the Health Care Financing Administration.*

Insurers and employers should report beneficiaries' Medicare identification number; the type of policy purchased or received (i.e., employer-provided or Medigap plan); whether the coverage is group or individual insurance; and the plan designation of standard Medigap plans (Plans A-J). HCFA should establish an approach and timetable for implementing these mandatory requirements.

This chapter begins with a basic discussion of Medigap and employer-provided supplemental insurance, the two main forms of private secondary insurance available to beneficiaries. It then describes the interactions between supplemental insurance, Medicare spending, and beneficiary access, as well as issues related to portability in the secondary insurance market. The interface of employer-sponsored and Medicare benefits is explored, and the evaluation of Medicare SELECT, a network-based Medigap demonstration project, is then summarized. The need for improved data collection on beneficiaries' secondary insurance status is discussed and expected changes to the administration of Medicare are described, thereby establishing the context for the Commission's recommendation. The chapter concludes by highlighting future Commission work on supplemental insurance. Policy issues related to beneficiaries who have Medicaid to supplement Medicare are discussed in Chapter 19.

## **MEDICARE BENEFICIARIES' USE OF SECONDARY INSURANCE**

Medicare covers roughly 45 percent of the total health care costs of the elderly (HCFA 1995a).<sup>1</sup> Private sources—including supplemental insurance and out-of-pocket payments—cover about 37 percent. Medicaid and other public insurance cover the rest (HCFA 1995a).

In 1995, 87 percent of beneficiaries not enrolled in a Medicare managed-care plan had some insurance to augment their Medicare coverage (Figure 15-1). One-third had Medigap insurance only, just over 31 percent had employer-provided benefits, and another 6 percent had both Medigap and employer-provided coverage. Medicaid supplemented Medicare benefits for about 15 percent of beneficiaries.<sup>2</sup>

---

<sup>1</sup> Medicare pays 70 percent of the elderly's hospital bills, 61 percent of costs for physicians' services, 15 percent of costs for other personal care services, and less than 2 percent of nursing home costs (HCFA 1995a).

<sup>2</sup> Data reported in the Commission's 1996 annual report were drawn from a study that looked at the supplemental coverage of elderly beneficiaries living in the community (Chulis et al. 1995). This year's analysis included both non-aged disabled and institutionalized beneficiaries, which explains the difference in the reported percentage of beneficiaries with Medicaid coverage.

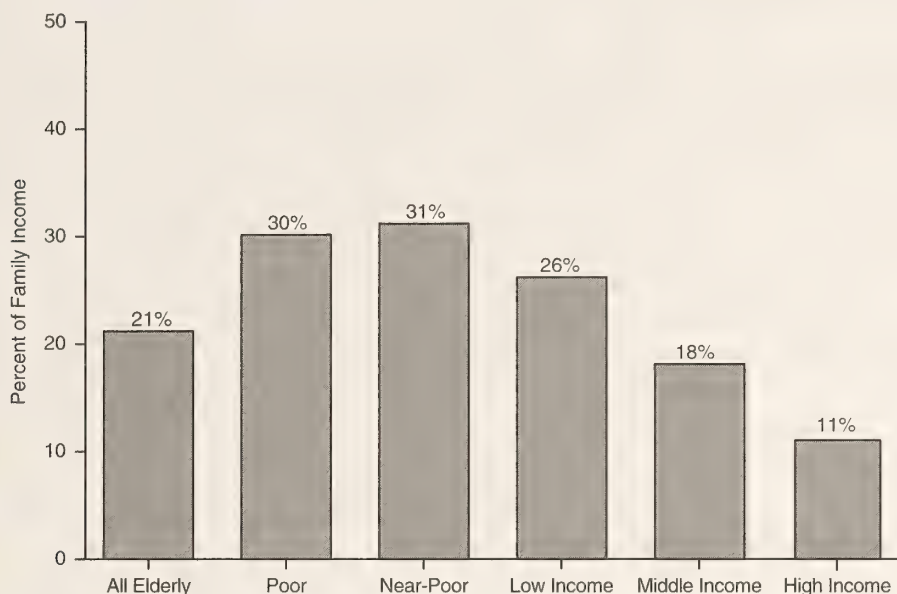
- Chulis, George S., Franklin J. Eppig, Mary O. Hogan, et al., "Health Insurance and the Elderly: Data from MCBS," *Health Care Financing Review* 14(3):163-181, Spring 1993.
- Escarce, Jose J., Kenneth R. Epstein, David C. Colby, and J. Sanford Schwartz, "Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests," *American Journal of Public Health* 83(7):948-954, July 1993.
- Geiger, H. Jack, "Race and Health Care—An American Dilemma?" *New England Journal of Medicine* 335(11):815-816, September 12, 1996.
- Laschober, Mary A., and Gary L. Olin, *Health and Health Care of the Medicare Population: Data from the 1992 Medicare Current Beneficiary Survey* (Rockville, MD: Westat, Inc., November 1996).
- Moon, Marilyn, and Crystal Kuntz, *Increasing Medicare's Part B Premium*, report prepared by the Urban Institute for the Commonwealth Fund (New York: Commonwealth Fund, November 1996).
- Moon, Marilyn, Crystal Kuntz, and Laurie Pounder, *Protecting Low-Income Medicare Beneficiaries*, report prepared by the Urban Institute for the Commonwealth Fund (New York: Commonwealth Fund, November 1996).
- Moon, Marilyn, *Restructuring Medicare's Cost-Sharing*, report prepared by the Urban Institute for the Commonwealth Fund (New York: Commonwealth Fund, November 1996).
- Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series, No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).
- Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, No. 93-2 (Washington, DC: 1993).
- Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, No. 95-1 (Washington, DC: 1995).
- Physician Payment Review Commission, *Monitoring Access of Medicare Beneficiaries*, No. 96-1 (Washington, DC: 1996).
- Schur, Claudia L., Amy B. Bernstein, and Marc L. Berk, "The Importance of Distinguishing Hispanic Subpopulations in the Use of Medical Care," *Medical Care* 25(7):627-641, July 1987.



Ware, John E., "What Information Do Consumers Want and How Will They Use It?" *Medical Care* 33(1):JS25-JS30, Supplement 1995.

Weissman, Joel S., and Arnold M. Epstein, *Falling through the Safety Net* (Baltimore: Johns Hopkins University Press, 1994).

**Figure 14-6. Average Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income by Poverty Status, 1996**



SOURCE: Moon et al. 1996.

NOTE: The poor are those with incomes at 100 percent or less of the poverty level; the near poor are those between 100 and 125 percent of poverty; low income are those between 125 and 200 percent of poverty; middle income are those between 200 and 400 percent of poverty; and high income as those with incomes over 400 percent of poverty.

18 percent of their household income on health care, the oldest beneficiaries (80 and older) spend about 25 percent (Moon et al. 1996).

Spending on health insurance premiums accounts for most of these out-of-pocket expenditures. Combined, Medicare Part B premiums, individual private insurance premiums, and employment-related insurance premiums account for about 45 percent of out-of-pocket costs of noninstitutionalized beneficiaries. Of the remaining costs, 17 percent is spent on physicians' services, 13 percent on home health services, 10 percent on prescription drugs, and 7 percent for hospital services. The remaining 8 percent is split between vision and dental services and durable medical equipment (AARP 1995).

### **Financial Liability for Physicians' Services**

Policies designed to limit beneficiary financial liability have generally proven successful. In 1996, more than three-fourths (78 percent) of providers who served Medicare beneficiaries were enrolled in the participating physician program, compared with 52 percent of physicians with PAR agreements in 1992. Participation rates range from a high of 92 percent in North Dakota to a low of 60 percent in Idaho. These participating providers accounted for about 92 percent of Medicare charges for physicians' services last year. The proportion of Medicare claims, submitted by participating and

nonparticipating physicians, paid on assignment is high and continues to rise, from about 70 percent in 1986 to 96 percent in 1996.<sup>11</sup>

For the remaining charges that are not assigned, beneficiaries' cost sharing has largely been contained by Medicare's limiting charges. As a percentage of Medicare payments, balance bills have been declining. On average, balance bills were 23 percent of Medicare payments in 1993, 17 percent in 1994, and 15 percent in 1995. Preliminary analysis of unassigned claims with balance bills submitted during 1996 reveals that on average, balance bills were again 15 percent of the fee schedule payment. Although the 1996 average of 15 percent may indicate that some bills remain above the limiting charge, previous Commission analyses have found that most charges that exceed the limit do so by relatively small amounts. The increased compliance with the limiting charge is most likely related to Health Care Financing Administration (HCFA) initiatives aimed at better informing providers and beneficiaries of overcharges. Legislation enacted in 1994 clarified HCFA's authority to enforce the charge limits and require providers to refund any overcharges.

### **Future Work on Monitoring Out-of-Pocket Spending**

Assessing out-of-pocket health care costs and understanding the financial burden these costs impose on different types of beneficiaries is critical to discussions about how to reform Medicare. Proposals to increase the Medicare Part B premium or to charge wealthier beneficiaries a higher premium have received attention recently as policymakers look for ways to contain rising program costs.

The Commission's upcoming report on beneficiary financial liability will include more detailed analyses on out-of-pocket health care spending. The most current data from the cost and use supplement to the 1992 MCBS will be used for these analyses.<sup>12</sup> The analyses will focus on how out-of-pocket spending varies among different segments of the Medicare population. Of particular interest are the out-of-pocket expenses of traditionally vulnerable groups of beneficiaries, including African Americans, Hispanics, those without supplemental insurance coverage, and the oldest and poorest beneficiaries.

### **REFERENCES**

Aday, LuAnn, and Ronald Andersen, "Equity of Access to Medical Care: A Conceptual and Empirical Overview," *Medical Care* 19(12):4-27, December 1981.

American Association of Retired Persons, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington, DC: 1995).

---

<sup>11</sup> The estimate for 1996 is based on claims data from the first six months of that year.

<sup>12</sup> Once data from the 1993 and 1994 MCBS are released, the Commission will update its analyses using the 1992 data as a baseline.



Recent trends in Medigap premiums have raised concerns among consumer groups about beneficiaries' ability to continue to afford such coverage. For example, premiums for community-rated, guaranteed issue policies offered through the American Association of Retired Persons rose an average of 26 percent in 1996 and are expected to rise by about 13 percent in 1997 (GAO 1996a; Prudential 1997a).<sup>4</sup> Another recent study of Blue Cross Blue Shield standard Medigap policies in 35 states found that while some premiums declined or remained flat, nearly half of the policies experienced premium increases of at least 10 percent between 1995 and 1996 (Families USA 1996). Premiums rise for a number of reasons, including periodic increases in Medicare deductibles; increased or unusual claims experience; modifications to state-level insurance policy; changes in claims processing or administration (e.g., the introduction of automatic claims processing systems); or the effects of the underwriting cycle. Greater use of outpatient hospital services, for which beneficiaries (and consequently Medigap insurers) must pay 20 percent of hospital charges, has also contributed to higher Medigap premiums (Pear 1995).

## **EMPLOYER-PROVIDED SUPPLEMENTAL INSURANCE**

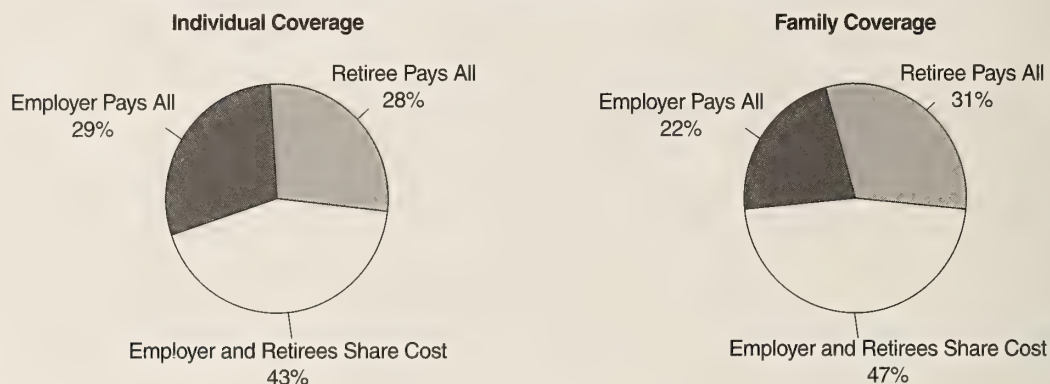
Many employers provide health insurance benefits to their Medicare-eligible retirees as part of their company retirement package. These benefits may be offered for either competitive or contractual reasons. A firm may decide to provide retiree health coverage because it is standard practice in the industry or because both the firm and its potential employees regard the benefits as vital to their total compensation package. Many companies, particularly in manufacturing industries, offer retiree health benefits partly because they are contractually obligated to do so through labor agreements.

In 1995, employer-provided supplemental benefits augmented Medicare coverage for about 37 percent of Medicare beneficiaries. The costs of this coverage are generally shared by the employer and the retiree. In 1996, 72 percent of large firms subsidized individual coverage for their Medicare-eligible retirees (Figure 15-2) (Foster Higgins 1997). These subsidies are important to many beneficiaries. One study estimated that up to 20 percent of Medicare-eligible retirees could not afford such coverage without an employer subsidy and that older women, African Americans, and single beneficiaries would be most adversely affected if these subsidies were reduced significantly (Shea and Stewart 1994). In 1996, retirees of large firms spent \$948, on average, for their employer-sponsored supplemental coverage (Foster Higgins 1997).

---

<sup>4</sup> The 1996 figure represents a national weighted average of premium increases for both standard and non-standard plans. Average pre-OBRA90 plan premiums increased by 29 percent and standard plan premiums went up by 23 percent in 1995. These increases followed two years of zero to 1 percent growth in Medigap premiums (GAO 1996a). The 1997 figure is a preliminary estimate of the national weighted average of premium increases for both standard and non-standard plans.

**Figure 15-2. Large Firms' Premium Contributions for Medicare-Eligible Retirees' Health Coverage, by Type of Coverage, 1995 (percentage)**



SOURCE: Foster Higgins 1997.

NOTE: Large firms are defined as those with more than 500 employees. All totals may not add to 100 due to rounding.

Employer-provided retiree health plans typically are more comprehensive than Medigap coverage. Many include catastrophic coverage or limits on out-of-pocket expenses within maximum lifetime-benefit caps; about 30 percent cover vision and dental care (GAO 1994). While retiree plans often include deductibles and cost-sharing requirements, they almost always cover prescription drugs (Clark and Kreps 1989; GAO 1994).

Most firms set eligibility requirements for retiree health coverage. These generally include participation in the employer's health plan prior to retirement and at least 10 years of service (Foster Higgins 1997). Usually, retirement directly from the firm is also required. Many companies tie eligibility for retiree health benefits to that for pension benefits (Morrisey 1993; Clark et al. 1994).

The number of employers providing health benefits to their Medicare-eligible retirees is declining. Between 1994 and 1996, the number of large firms (i.e., those with more than 500 employees) offering such benefits dropped from 40 percent to 33 percent (Figure 15-3) (Foster Higgins 1997). Recently, many other employers have begun to modify benefits, tighten eligibility requirements, and restrict coverage options for their Medicare-eligible retirees. These changes reflect a number of factors, among them rising medical costs, increases in the ratio of retired to active workers, and actual or anticipated changes in Medicare payment policy (Clark et al. 1994).

**Figure 15-3. Percentage of Large Firms Offering Retiree Health Coverage to Medicare-Eligible Retirees, 1993-1996**



SOURCE: Foster Higgins 1997.

NOTE: Large employers are those with more than 500 employees.

The most significant impetus for changes to retiree health benefits, however, has been the enactment of Financial Accounting Standard 106 (FAS 106). That rule requires companies to include their current and anticipated costs for promised retiree health benefits as a financial liability on their annual financial statements. The adoption of this rule ended most companies' practice of funding retiree health benefits on a pay-as-you-go basis. FAS 106 also gave firms a major incentive to limit retiree health care liabilities.<sup>5</sup>

### **The Evolution of Retiree Health Benefits**

Historically, employers have used a defined-benefit approach to providing health benefits to their Medicare-eligible retirees. This approach promises retirees coverage for a particular set of benefits, often based on the coverage provided to active employees. Defined-benefit plans meet employers' goals of establishing and maintaining parity of coverage between working and retiree populations, as well as among geographically disbursed retirees.

---

<sup>5</sup> For more information on other laws and regulations related to employer-provided health benefits, see the Commission's *Annual Report to Congress 1996* (PPRC 1996).



Benefits included in a defined-benefit plan may overlap significantly with basic Medicare benefits (Jensen and Morrissey 1992). As a result, employers must coordinate their coverage with Medicare's, which is the primary payer for all retired beneficiaries. Employers have adopted four basic approaches to achieving such integration: coordination-of-benefits coverage, wraparound coverage, carve-out coverage, and exclusion coverage.<sup>6</sup> Each of these methods augments Medicare's payment for jointly covered services and may or may not make the beneficiary responsible for some cost sharing.

Recently, in response to rising health care costs and FAS 106, some employers have moved to a defined-contribution model for their retiree health benefits. Many more are considering such a move (Foster Higgins 1995; Hay Group 1996). Defined-contribution health plans are modeled after the defined-contribution pension plans offered by many employers. Although the form and details may vary, these plans essentially provide retirees with a predefined yearly or overall employer contribution toward the purchase of health benefits. Typically, the contribution is made on an annual basis and is based on a formula. The formula may take the retiree's age, years of service with the employer, other employer-specific criteria (such as company profitability), or a combination of these factors into account when determining the contribution. Some companies provide a uniform annual dollar amount (or defined-dollar contribution) to all retirees. In any case, payments generally are made directly to the retiree's selected health plan. Retirees must pay any difference between their employer's contribution and their selected plan's premium. Defined-contribution plans allow employers to reduce their long-term liability for health care costs and make that liability more predictable.

Employers play a substantial role under both defined-benefit and defined-contribution plans. Often, this includes selecting health plans from which retirees can choose. Companies actively negotiate with individual health plans for specific benefit packages and coverage options, and then make selected options available to retirees. Options may include a straight supplemental/Medigap-type plan that augments traditional Medicare, enrollment in a Medicare risk plan, or enrollment in a managed-care plan that does not participate in Medicare.<sup>7</sup> By selecting and negotiating with individual health plans, employers maintain their link between retirees and health plans and can potentially use their purchasing power to negotiate favorable benefit packages and premium rates. Employers also retain their role as an advocate for the retiree.

---

<sup>6</sup> Carve-out plans deduct the amount that Medicare pays for a service from the plan's allowed charge for the same service, and pay the difference. The beneficiary must pay any balance remaining on the bill as well as plan deductible and coinsurance amounts. Wraparound plans resemble Medigap insurance and tend to cover Medicare cost-sharing requirements and additional benefits like prescription drugs and preventive care. They may or may not require cost sharing. Under coordination-of-benefits coverage, the employer-sponsored plan typically pays the difference between actual charges and Medicare's payment up to the amount that the plan would have been willing to pay in the absence of Medicare. As a result, Medicare-covered services are essentially free, while those that Medicare does not cover are subject to the employer-sponsored plan's coinsurance requirements. Under exclusion coverage, Medicare payments are subtracted from actual claims and the employer-sponsored plan's benefits are applied to the balance. This generally leaves beneficiaries responsible for the employer's plan's cost sharing and deductibles.

<sup>7</sup> When a retiree enrolls in a non-Medicare managed-care plan, the employer contracts with the plan to provide supplemental benefits, and the health plan bills Medicare on a fee-for-service basis for all Medicare-covered services.

Defined-benefit and defined-contribution plans have different ramifications for retirees. Defined-benefit plans guarantee retirees a certain minimum level of coverage and place the primary liability for increased costs on the employer providing the benefit. The retiree becomes liable for cost increases only when the employer chooses to increase premiums, copayments, or deductibles. Defined-contribution plans, on the other hand, place the risk for increased costs entirely on retirees. As health insurance premiums rise over time, the purchasing power of employers' defined contributions erodes and retirees become liable for the difference. While employers may make ad hoc decisions to increase contributions and counteract the effects of inflation, most defined-contribution plans do not include any built-in adjustments to the contribution to account for inflation.

Retirees in both defined-benefit and defined-contribution plans gain from employers' involvement in their health coverage. Employers' negotiations with plans help hold down costs for retirees and employers alike. Retirees also benefit from any information they get from their employers about their Medicare and employer-provided coverage options. In some cases, retirees also gain continuity of the care and benefits they received as active workers.

### **Employers' Use of Medicare Risk Plans**

Increasingly, employers are using Medicare risk plans and other managed-care organizations to deliver defined-benefit and defined-contribution retiree health benefits to their Medicare-eligible retirees. In 1996, 38 percent of large employers offered at least one Medicare risk plan to their retirees, up from only 7 percent three years earlier (Foster Higgins 1997). Over 70 large employers with more than 2 million Medicare-eligible retirees have joined the National Medicare HMO Initiative to negotiate contracts with Medicare risk plans for their retirees. That initiative evaluates plans on the basis of quality, access, patient satisfaction, and efficiency, contracting only with those plans that meet the group's standards. The group negotiates for the delivery of three standard supplemental plans, which ensures equity among retirees nationwide.<sup>8</sup> A growing number of employers are also offering retiree health benefits only through Medicare risk plans.

Enrolling beneficiaries in Medicare risk plans can reduce employers' retiree health costs significantly while providing expanded benefits. Bethlehem Steel, for example, has found that the premium costs for retirees enrolled in Medicare risk plans are roughly one-quarter to one-third of the cost of its wraparound indemnity supplemental option, because many risk plans already cover some supplemental benefits (Romeo 1997). The company estimates that it saves \$600 annually for each Medicare beneficiary in a Medicare risk plan and that it has reduced its FAS 106 liability by \$68 million by enrolling retirees in such plans (Romeo 1997).<sup>9</sup> Retirees have benefited because they receive better coverage and their cost-sharing burden is less in the risk plan than through the company's wraparound

---

<sup>8</sup> Many Medicare risk plans already cover some supplemental benefits for enrolled beneficiaries. When the Initiative negotiates its supplemental benefits packages with these plans, it is negotiating for benefits in excess of what the plan already provides.

<sup>9</sup> The potential for such savings could diminish if Medicare changes how it pays managed-care plans.

indemnity plan (Romeo 1997). Many other employers are achieving similar results by increasing retiree enrollment in Medicare risk plans.

Some retirees are given direct financial incentives to join Medicare risk plans. For example, some employers rebate the Medicare Part B premium to those retirees who enroll in such a plan. Other beneficiaries with employer-provided defined contributions may be able to maximize their benefits and the value of their employer subsidy by enrolling in Medicare risk plans, because benefits purchased through these plans are often less expensive than similar benefits bought through indemnity plans.

## **POLICY ISSUES FOR MEDICARE**

The rest of this chapter focuses on issues and challenges facing policymakers as they examine secondary insurance and policy options to reform supplemental insurance and the Medicare program as a whole. These include the interactions between secondary insurance, Medicare spending, and beneficiary access; the implications of secondary insurance for efforts to reform the Medicare program; and differences in the rating, underwriting, and portability standards among health plans and insurers in the secondary insurance market. Issues related to employer-provided supplemental insurance are also discussed. Finally, issues surrounding the recent evaluation of a demonstration project that allowed insurers to create network-based supplemental insurance products are presented. They highlight the need to collect basic information about Medicare beneficiaries' supplemental insurance on a routine basis.

### **Secondary Insurance, Medicare Spending, and Beneficiary Access**

There is a tension between the importance of supplemental insurance to beneficiaries and the implications of this coverage for Medicare outlays. Lack of supplemental coverage is associated with reduced access to care, as indicated by measures such as whether a beneficiary has a physician or physician's office as a regular source of care, is more likely to delay care because of cost, and has had a medical problem for which the beneficiary did not see a physician.<sup>10</sup> A recent study of Medicare beneficiaries with arthritis similarly demonstrated that beneficiaries without supplemental coverage may experience greater barriers to care than those with such coverage (Grana and Stuart 1996/97). But supplemental insurance raises Medicare's costs significantly and may limit the effect of efforts to reform Medicare.

Medicare cost-sharing requirements are intended, in part, to encourage cost-conscious utilization. Insurance that supplements Medicare by covering deductibles and coinsurance removes these incentives. As a result, secondary insurance has important implications for the likely effects of different types of Medicare reforms. For example, by covering copayments and deductibles, secondary insurance

---

<sup>10</sup> For more information on the relationship between secondary insurance and beneficiaries' access to care, see Chapter 14.



may limit the effectiveness of policies, such as those used by preferred provider organizations or point-of-service plans, that relate beneficiaries' coinsurance to their choice of provider. Similarly, the effects of any changes to Medicare's cost-sharing requirements would affect beneficiaries differently, depending on their supplemental insurance status. Those without secondary coverage would be directly affected. Those with supplemental insurance, however, would be only indirectly affected by such changes and only to the extent that insurers or employers responded by changing premiums, copayments, or benefits. As long as insurers are able to supplement Medicare coverage, these problems will not be confined to fee-for-service Medicare, but will affect other Medicare plan options as well.

Many analyses have addressed how supplemental insurance affects beneficiaries' use of Medicare-covered services and the cost of those services to Medicare. Typically, these studies have estimated that Medicare spending for beneficiaries with supplemental coverage are one-quarter to one-third higher, on average, than expenditures for beneficiaries without such coverage (Chulis et al. 1993; McCall et al. 1991; Taylor et al. 1988; Christensen et al. 1987; and Link et al. 1980).

Last year, a Commission analysis of the Medicare Current Beneficiary Survey (MCBS) found a similar effect: Medicare expenditures for beneficiaries covered by supplemental insurance were about 30 percent higher than they were for those without such coverage (PPRC 1996). Subsequent analysis showed that the effect of secondary coverage on Medicare expenditures differs, depending on the source of that coverage.<sup>11</sup> Expenditures for beneficiaries having Medicare only are less than 75 percent of those for beneficiaries with Medigap insurance. Spending for beneficiaries with employer-provided benefits average 10 percent less (Figure 15-4).

These results reflect the difference in spending by source of insurance, once other factors have been considered. In particular, the effects of beneficiaries' age, race, sex, income, health status, activities of daily living restrictions, urban/rural location, and institutional and disability status have all been removed. As the results show, even after controlling for these factors, higher costs and service use are still associated with supplemental insurance. High service use among beneficiaries with secondary insurance appears to be a direct consequence of having such insurance, presumably reflecting the reduced financial burden associated with using additional services.

Higher utilization among beneficiaries with supplemental insurance translates into increased Medicare costs because Medicare is the primary payer for those services. The MCBS analysis found that per capita expenditures for Medicare beneficiaries with Medigap insurance were from \$1,000 to \$1,400 higher than those for beneficiaries with Medicare only. Per capita spending for beneficiaries with employer-provided supplements were from \$700 to \$900 higher than those for beneficiaries with no supplemental coverage.

---

<sup>11</sup> The results from this year's analysis of MCBS data differ somewhat from those presented in the Commission's 1996 annual report. This year, beneficiaries who reported purchasing or receiving their supplemental insurance through a union were reclassified as having Medigap insurance to reflect the fact that union-sponsored supplemental insurance tends to resemble the first-dollar coverage aspect of Medigap policies more closely than other employment-related supplemental insurance. As a result of this reclassification, estimated expenditures for beneficiaries with individually-purchased Medigap insurance increased somewhat, and estimated expenditures for beneficiaries with employer-provided supplemental insurance were reduced.

**Figure 15-4. Comparison of Projected Per Capita Spending for Average Beneficiaries, by Type of Supplemental Insurance and Year**



**SOURCE:** Physician Payment Review Commission analysis of data from the 1993 and 1995 Medicare Current Beneficiary Survey. The sample size for 1993 was 11,285 and the sample size for 1995 was 13,261.

**NOTE:** These spending levels represent the expected differences in outlays after other factors have been taken into account.

As noted, Commission analysis has found that beneficiaries with supplemental insurance report fewer barriers to care than those without it, suggesting that some of the additional care they use may be medically necessary or appropriate. Given these observations, proposals to modify supplemental insurance must be considered carefully in terms of the trade-offs between a reduction in overall Medicare spending and the protection that such insurance provides to Medicare beneficiaries. Reforming the structure of supplemental benefits and ensuring their equitable distribution may be one way to maintain the availability of such coverage while recognizing its importance to beneficiaries and working to control overall Medicare expenditures.

### **Rating, Underwriting, and Portability**

Different rating and underwriting practices in the Medigap and Medicare risk-contracting markets affect Medicare beneficiaries' ability to shift among supplemental and basic Medicare coverage options. This section discusses current rating, underwriting, and portability standards in the Medigap

and Medicare managed-care markets and the ability of beneficiaries to move among the various options. The implications of introducing wider portability into the secondary insurance market are presented, and recent legislative approaches to creating such portability are outlined.

**Current Rating, Underwriting, and Portability Standards: Medigap Policies.** Under current law, Medigap insurance is offered on a guaranteed-issue basis only during the first six months of an elderly beneficiary's enrollment in Medicare. After this one-time open enrollment period, beneficiaries are not legally assured of the ability to purchase such coverage, and the price for individual policies may be based on any rating characteristics allowed by individual states. Within the guaranteed open enrollment period, insurers in some states may impose six-month preexisting condition exclusions on a policywide basis. Renewal of Medigap policies is guaranteed. Insurers may cancel policies only if beneficiaries fail to pay their premiums. Premium increases must be applied uniformly to all policies and approved by the appropriate state agency.

Medigap insurers use three basic rating methods to set premium prices: community, age-at-issuance, and age-attained rating. Under community rating, all beneficiaries, regardless of age or health status, are charged the same premium. Age-at-issuance policies base the premium price on the age of the beneficiary when the policy was first issued. Age-attained rating relates premiums to the actual age of the beneficiary paying for the coverage. The cost for community and age-at-issuance rated policies rises only with inflation and cost experience, while age-attained premiums increase with inflation, cost experience, and age.

Beneficiaries with Medigap insurance have certain protection from the imposition of preexisting condition exclusions if they decide to switch Medigap policies. Current law allows continuously insured beneficiaries who have satisfied the six-month waiting period under one Medigap policy to avoid exclusions for previously covered benefits under new replacement policies. The law does not, however, ensure that another insurer will agree to sell a replacement policy to an individual beneficiary (i.e., replacement policies are not guaranteed issue).

**Current Rating, Underwriting, and Portability Standards: Medicare Risk Plans.** Medicare risk plans often cover supplemental benefits for their enrollees. There may or may not be an additional cost associated with these benefits. Where there is an additional premium, it must be community rated. Medicare risk plans must also accept all beneficiaries who live in their service area, regardless of their health status. Because of these requirements, beneficiaries joining or shifting among Medicare risk plans do not face any underwriting barriers when making these moves.<sup>12</sup> Furthermore, risk plans cannot impose preexisting condition exclusions on new enrollees.

---

<sup>12</sup> While beneficiaries pay community-rated premiums to Medicare risk plans, Medicare's payment to the plan is adjusted for several demographic factors, including age. As a result, the plan appears to be community rated to the beneficiary, but Medicare's payment to the plan reflects the beneficiary's demographic risk status.



**Beneficiaries' Ability to Move among Supplemental Insurance Options.** Beneficiaries switching from employer-provided secondary insurance or Medicare managed-care plans to Medigap insurance are not entitled to the protection enjoyed by beneficiaries changing Medigap policies. Once their initial open enrollment period has ended, these beneficiaries may be unable to purchase Medigap insurance due to medical underwriting, subject to six-month preexisting condition exclusions, and rated on any characteristics allowed by the state for whatever Medigap policy they purchase.

As a result, some beneficiaries may purchase or retain Medigap policies that duplicate their employer-provided or risk-plan benefits. For example, many beneficiaries with employer-sponsored coverage purchase Medigap insurance to protect them against a future reduction or elimination of their employer-provided benefits (GAO 1994). Commission analysis of the 1993-1995 MCBS found that roughly one in five Medicare beneficiaries with employer-sponsored coverage also holds Medigap insurance. Similarly, Medicare risk-plan enrollees sometimes carry other supplemental insurance in case they decide to disenroll from their risk plan and reenter traditional Medicare. A recent Commission-sponsored survey estimated that 5 percent of beneficiaries in Medicare risk plans also have supplemental coverage (Nelson et al. 1996).

Different rating and underwriting practices in the Medigap and managed-care markets may deter beneficiaries from entering or trying Medicare managed-care options. Beneficiaries choosing between traditional Medicare plus Medigap insurance and a Medicare risk plan must be able to weigh differences in prices and benefits, as well as the likelihood that they may want to change their coverage in the future. If beneficiaries enter managed care and discontinue their Medigap coverage, they may face higher prices or be unable to buy Medigap insurance if they subsequently want to return to traditional Medicare. Retaining their Medigap insurance, however, means paying for unneeded coverage. As beneficiaries are given more coverage options, the barriers to choice raised by different rating and underwriting practices will become even more critical.

Despite the current lack of de jure portability standards for beneficiaries switching among employer-sponsored, managed-care, and Medigap plans, beneficiaries often have the de facto ability to do so. A recent survey of the 25 largest Medigap insurers that collectively represent roughly 65 percent of the market found that 9 offer policies on a guaranteed-issue basis, while the other 16 use medical underwriting in issuing some or all of their Medigap policies (GAO 1996b). All Medicare beneficiaries currently have at least one alternative Medigap plan available to them on a guaranteed-issue basis. These alternatives are not guaranteed by law and may disappear in the future (GAO 1996b).<sup>13</sup>

**Goals and Rationales for Portability.** The concept of health insurance portability is founded on the belief that individuals should be able to change insurers without being subjected to waiting periods or exclusions. Portability has several important implications. First, it prevents individuals from being "stranded" in an insurance policy or locked into a job that provides particular coverage. Second, it may

---

<sup>13</sup> A few individual states require Medigap insurance to be sold on a guaranteed-issue basis or have established the state's Blue Cross Blue Shield Medigap plan as the insurer of last resort.

foster competition in the insurance market by reducing plans' ability to avoid insuring sicker individuals. Further, since portability benefits are structured to apply only to those who have been continuously insured, it dissuades individuals from postponing the purchase of health insurance until they are sick. Finally, portability is expected to eliminate beneficiaries' perceived need to purchase duplicative coverage.

Making it easier for beneficiaries to switch supplemental coverage may boost competitiveness in the Medigap market. The standardization of Medigap policies was intended, in part, to focus competition on service and price rather than on benefit offerings. It appears that this goal may not have been achieved. In the current Medigap market, the price of a single Medigap policy (e.g., Plan A) can vary by as much as 300 percent for a single beneficiary (Weiss Ratings 1995). While price differences can be related to several factors, this type of disparity is difficult to explain given the virtually identical nature of the product. In addition, despite sometimes dramatic differences in price, few beneficiaries appear to be changing their Medigap policies. Between 1991 and 1994, only 1 percent of beneficiaries included in the MCBS switched or dropped their Medigap or employer-provided supplemental plans (GAO 1996b). This finding suggests that beneficiaries are unaware of existing price variations for individual supplemental policies or that they are uncertain about their ability to purchase new supplemental policies.

**Concerns about Portability.** Implementing portability in the Medicare supplemental insurance market would affect individual segments of that market differently. When considering portability, three main issues need to be assessed: how it would affect premiums, whether it might result in adverse selection against traditional Medicare, and what implications it might have for Medicare program costs.

Introducing portability into the Medicare supplemental insurance market would probably change the population served by Medigap insurers. Beneficiaries who have employer-provided supplemental benefits or are enrolled in a Medicare risk plan would no longer need to purchase or keep duplicative Medigap coverage. Although these beneficiaries represent only a portion of Medigap purchasers, they impose few costs on Medigap insurers and may therefore help to hold down Medigap premiums. Removing these beneficiaries from the Medigap insurance pool could conceivably raise Medigap premium costs. Alternatively, beneficiaries' increased ability to move among supplemental policies could lead to more competition in the secondary insurance market, which could constrain Medigap premiums.

While portability would prevent beneficiaries from being locked in to a particular health plan, it could also affect Medicare spending. Adverse selection against traditional Medicare could be a concern if managed-care disenrollees had higher utilization and cost Medicare more money in fee for service than they would have if they had stayed in managed care. A recent Commission-sponsored survey and previous Commission work on risk selection suggest that, in fact, this might be a problem (Nelson et al. 1996; PPRC 1996). These studies found that beneficiaries who left managed-care plans were more



likely to have poor health status and more functional disabilities or to have higher spending than those who remained enrolled in Medicare fee for service.

Currently, some higher-cost beneficiaries may be staying in Medicare risk plans because they are concerned about their ability to obtain Medigap insurance. Granting them portability could raise supplemental insurance premiums and Medicare program costs if, in fact, they used a disproportionate number of services after disenrolling. Because beneficiaries can leave managed-care plans on a monthly basis, opportunities for selection may be increased. This could create concerns and affect costs for both individual insurers and the Medicare program as a whole.

**Elements of Portability.** A portability policy must include several elements that contribute to seamless transitions among insurance options. Two key elements are waivers of preexisting condition exclusions for continuously insured beneficiaries, and guaranteed issue of replacement policies. Within a system of portable health benefits, a grace period typically is established during which replacement insurance is sold on a guaranteed-issue basis.

Standards for risk-rating replacement policies are a third optional element of portability. Restricted rating standards are meant to ensure that insurance not only is available, but that it is relatively affordable. Rating restrictions can be structured to allow only certain broad types of rating categories (e.g., community or age-at-issuance rating), to establish a uniform list of criteria upon which individual policies can be rated (e.g., age, sex, disability status, ZIP code, etc.), or to keep premium variation across groups within certain limits.

Other more technical elements must also be addressed when constructing a portability policy. These include setting a time frame for eligibility, determining what benefits to include, implementing standards, and deciding whether and what type of information beneficiaries should receive concerning plan options.

**Recent Activity on Portability.** Recently, both the Congress and the Administration have developed proposals to provide guaranteed portability to Medicare beneficiaries. A bipartisan bill to establish guaranteed issue and portability for those with secondary insurance has been introduced in both the House and the Senate. The Administration has included proposals related to supplemental insurance portability in its fiscal year 1998 budget proposal.

Originally introduced in the 104th Congress, the proposed Medigap Amendments of 1997 would establish guaranteed-issue requirements and ban preexisting condition exclusions for continuously insured beneficiaries.<sup>14</sup> Under certain circumstances, qualifying beneficiaries would have 63 days to purchase new Medigap coverage without preexisting condition exclusions. Among others, these circumstances would include a beneficiary's move out of the plan's service area; the termination of the

---

<sup>14</sup> The Medigap Amendments of 1997 (H.R. 625; S. 302) were introduced by Representatives Nancy Johnson and John Dingell and by Senators John Chafee and John D. Rockefeller, IV.



plan's risk contract; or the insurer's withdrawal from the market. Beneficiaries would also qualify if their employer plan were substantially modified, reduced, or terminated, or if they disenrolled from a Medicare HMO or Medicare SELECT plan within 12 months of first enrolling in such a plan.

Portability and guaranteed issue requirements would apply to all Medigap policies with comparable or less generous benefits than those a beneficiary was replacing. Insurers selling supplemental insurance to qualifying beneficiaries could not discriminate in pricing based on health status, previous claims experience, medical conditions, or genetic information. The proposed legislation did not address the use of various rating practices in the Medigap market. Besides banning preexisting condition exclusions for insurance purchased during a beneficiary's initial open enrollment period, the bills would also establish an equivalent open enrollment period for nonelderly beneficiaries when they became eligible for Medicare.<sup>15</sup>

In its 1998 budget proposal, the Clinton Administration proposed establishing a 30-day annual open enrollment period for all Medicare managed-care and supplemental insurance options. All newly eligible elderly and nonelderly Medicare beneficiaries would also be granted an open enrollment period upon becoming eligible for Medicare. Additionally, beneficiaries whose primary care physician left a plan or who moved to a new area would be entitled to an open enrollment period. The President's proposal calls for mandatory community rating of Medigap policies and eliminates insurers' ability to impose preexisting condition exclusions on beneficiaries who have recently had another Medigap policy, employer-sponsored coverage, or been enrolled in a Medicare risk plan.

### **Employers and Medicare: Policy Issues**

Employers' increasing use of managed-care plans to deliver supplemental benefits to their Medicare-eligible retirees raises a number of policy issues for Medicare. The most important ones relate to the potential for Medicare payment policy changes to influence how employers provide these benefits to retirees and to improve cooperation between the Medicare program and employers supplementing Medicare.

As discussed earlier, one of the primary reasons employers are turning to managed-care plans to deliver health benefits to their Medicare-eligible retirees is that it is often less costly than providing benefits through indemnity insurance. One explanation for this phenomenon is that Medicare's payment method to Medicare risk plans is flawed and may overpay some plans for the cost of the basic Medicare benefits package. These overpayments and Medicare's requirement that they be returned to beneficiaries in the form of extra benefits mean that, in some cases, Medicare subsidizes or covers the costs of supplemental benefits for enrolled beneficiaries.<sup>16</sup> As a result, an employer offering specific supplemental benefits to its Medicare-eligible retirees may find that in certain instances Medicare is

---

<sup>15</sup> Non-aged (i.e., disabled and ESRD) beneficiaries in most states are not entitled to a guaranteed open enrollment period until they become 65.

<sup>16</sup> Plans have the option of returning overpayments to Medicare, but none do.

already paying for these benefits. When that happens, the employer's costs for supplemental benefits are lowered, and the retirees' benefits are maintained.

**Medicare Policy Changes and Employer-Provided Health Benefits.** Policy changes to the Medicare program may influence employers to alter how they deliver retiree health benefits. For example, it seems likely that if Medicare risk payment policies are reformed, at least some employers (or retirees) will have to pay more for supplemental benefits than they do now. Employers could either absorb these higher costs, or attempt to counteract them by raising beneficiary cost-sharing requirements or by moving to defined contributions for retiree health benefits. In either of the latter two cases, beneficiaries' financial liability would go up. Movement to a defined contribution would also shift to retirees any further increases in the cost of supplemental benefits. Changes in beneficiaries' financial liability under traditional Medicare could have similar effects on employers' provision of retiree health benefits (Morrisey 1993).

Retiree health benefits experts have noted that movement toward a federal premium contribution system for Medicare could also encourage employers to adopt defined-contribution systems for their Medicare-eligible retirees. Employers offering defined-benefit coverage might feel legally or morally obligated to make up any difference between the Medicare contribution and the cost of plan premiums, as well as to maintain their coverage of supplemental benefits. Moving to a defined-contribution system would allow employers to continue to supplement Medicare's cost and coverage, without leaving themselves with an open-ended liability. The increase in beneficiaries' financial risks could be quite significant, since beneficiaries would be liable for any declines in both the value of the Medicare and employer contributions over time.

**Potential Medicare-Employer Cooperation.** A key question about employer-provided supplemental benefits relates to the possibilities for increasing cooperation between employers and the Medicare program. Previous experimentation in this area includes the Medicare Insured Group (MIG) demonstration, which sought to pay participating employers a capitated amount to provide all Medicare and supplemental benefits to their Medicare-eligible retirees. Despite initial interest in the demonstration, no employers pursued a MIG contract, citing a variety of concerns. Among these were limited opportunities for savings, the unlikelihood of being able to negotiate provider payments that were less than Medicare's, high administrative expenses, and significant start-up costs. Employers' inability to negotiate a satisfactory contract with a delivery system, their inexperience with managed care, or their lack of an existing managed-care network were also cited. Finally, employers were worried about the potential for biased selection into the MIG plan (HCFA 1995b; Maher 1995). Current employer interest in this type of option is likely to be minimal, considering their reluctance to increase their FAS 106 liability; uncertainty about potential Medicare restructuring; and concern about the adequacy, over time, of Medicare capitation payments (Helms 1996; Maher 1996).

As long as the liability for Medicare and supplemental benefits is distributed as it is, the use of Medicare risk plans is the most promising strategy for fostering cooperation between employers and Medicare. Currently, HCFA negotiates with risk plans for Medicare-covered services while employers



negotiate and contract with the plans for supplemental benefits. Any changes in Medicare's risk plan payment methodology could alter employers' delivery of health benefits to their retirees. Nonetheless, there may be ways to enhance coordination between these two purchasers, especially in areas like health plan quality measurement and communication among Medicare, employers, and risk plans.

Coordination with managed-care plans that do not participate in Medicare is another issue needing further study. Many Medicare-eligible retirees receive supplemental benefits through managed-care plans that bill Medicare on a fee-for-service basis. That system may or may not be worth perpetuating or encouraging. While the care these plans provide may be more cost-effective than that provided through traditional Medicare, whether these arrangements benefit Medicare is unclear.

### **Medicare SELECT: One Approach to Medigap Reform**

The Congress attempted to modify Medicare supplemental insurance through the Medicare SELECT demonstration project, a three-year, 15-state demonstration that allows supplemental insurers to offer network-based Medigap policies. Under SELECT, insurers can establish managed-care plans with restricted networks and cover only those services obtained through the SELECT network and emergency out-of-area care.<sup>17</sup> As with traditional Medigap policies, Medicare pays the majority of SELECT enrollees' costs, while SELECT plans cover only beneficiary cost sharing. Designed to introduce managed care to Medigap insurance, SELECT is expected to reduce Medicare costs by using networks of carefully selected, cost-effective providers to deliver care.

Medicare SELECT was created in OBRA90 and began on January 1, 1992, in 15 states. It was extended by the Social Security Act Amendments of 1994 (P.L. 103-432) for an additional six months and again, in 1995, for another three years. The 1995 legislation (P.L. 104-18) broadened SELECT's availability to all 50 states. It also authorized a permanent extension of the program unless SELECT policies were determined to cost more than traditional Medigap policies, result in higher overall Medicare costs, or diminish Medicare beneficiaries' access to care. Medicare SELECT policies must conform to one of the 10 federally standardized Medigap plans.<sup>18</sup>

**The SELECT Evaluation.** In May 1996, an evaluation of Medicare SELECT was submitted to the Congress in accordance with OBRA90 requirements. Conducted by the Research Triangle Institute (RTI) and Health Economics Research, Inc. (HER), the study examined a number of issues and discovered mixed results. It found that implementation of and requirements for SELECT policies varied widely among states and that SELECT networks were not always restrictive. Furthermore, except among HMOs, there was little active coordination or management of care within SELECT

---

<sup>17</sup> In practice, many SELECT insurers elect to pay out-of-network claims for their enrollees. Data from six states showed that out-of-network claims were paid 47 percent of the time for primary care physician services, 49 percent of the time for specialists, and 71 percent of the time for hospitals. As a result, what might have been a network-based supplemental plan looks more like a traditional, non-network supplement (Garfinkel et al. 1996).

<sup>18</sup> In Massachusetts, Minnesota, and Wisconsin, SELECT policies must conform to the state's Medigap insurance guidelines.



plans. Premiums for SELECT products were almost always below those for standard plans offered by the same insurer. Across insurers, however, premium differences depended on the beneficiary's age and the insurer's underwriting and rating practices (Garfinkel et al. 1996). At the time of the evaluation, roughly half a million beneficiaries held Medicare SELECT policies.<sup>19</sup>

To determine how Medicare SELECT affected Medicare spending, evaluators reviewed Medicare claims data for SELECT and non-SELECT beneficiaries in 11 states.<sup>20</sup> These data were collected for both groups of beneficiaries (matched by age, sex, and three-digit ZIP code) for nearly five years, beginning in January 1991. Beneficiaries with no supplemental coverage were excluded, and each state was analyzed separately. The claims analysis was designed to identify differences in cost and utilization patterns between SELECT and non-SELECT beneficiaries.<sup>21</sup> Results of the analysis were mixed (Garfinkel et al. 1996).

The total allowable Medicare expense (including copayments and deductibles) for SELECT and non-SELECT beneficiaries was the key variable studied. As for the overall effects on Medicare spending, there was no consistent pattern for SELECT. Costs rose in five states, decreased in four, and showed no significant difference in two (Table 15-2) (Garfinkel et al. 1996).<sup>22</sup> No consistent, discernable, or obvious patterns in expenditures explained the different experience of each state: only differences in the cost and use of ambulatory care tended to predict individual states' overall costs with any regularity (Garfinkel et al. 1996).

**Conclusions about the Evaluation.** The SELECT evaluation was intended, in part, to reveal whether SELECT raised or lowered per capita Medicare spending. The study could not definitively answer this question because researchers' lacked information on beneficiaries' prior supplemental insurance status. Collecting data was difficult so researchers could not distinguish between first-time purchasers of supplemental insurance and beneficiaries who were switching to a SELECT or other standard Medigap plan from another Medigap policy. Investigators had little leverage to obtain desired information from insurers (especially those not participating in SELECT). They also found that not all insurers routinely collect the data needed for the evaluation.

---

<sup>19</sup> For more on Medicare SELECT, see PPRC 1996; Garfinkel et al. 1996; and Lee et al. 1996.

<sup>20</sup> To be included in the claims analysis, states must have had enrollment in Medicare SELECT plans by February 1, 1994. Illinois, Massachusetts, and Washington had no enrollment by that date, and North Dakota was eliminated due to its small sample size.

<sup>21</sup> The analysis consisted of a four-way quasi-experimental (i.e., a pre/post with control) design that compared the before and after enrollment experience of Medicare beneficiaries newly enrolled in SELECT with the before and after enrollment experience of beneficiaries newly enrolled in standard, non-network Medigap plans. A fixed-effects model, which looks only at changes in each beneficiary's average spending over time and ignores the average level of spending for individual beneficiaries, was used. That model provides a fairly strong control for differences between SELECT and non-SELECT populations because any permanent (time invariant) differences across individuals (i.e., consistent patterns of high or low spending) are factored out of the data before estimating the impact of SELECT on costs.

<sup>22</sup> Measuring only the effect of having any standard Medigap policy, however, the fixed-effects model obtained positive estimates for all 11 states analyzed. The estimates were statistically significant for nine states, ranging from 3.4 percent to 24.1 percent. These findings support the theory that supplemental coverage is associated with higher utilization and costs.

**Table 15-2. Estimated Medicare SELECT Cost Impacts**

State	Sample Size (Number of SELECT Enrollees)	Sample Size (Number of Non- SELECT Enrollees)	Estimated SELECT Effect (Percent Change in Costs)
Alabama	30,793	4,367	15.7% <sup>b</sup>
Arizona	1,189	1,152	16.4 <sup>a</sup>
California	38,680	31,415	-8.2 <sup>b</sup>
Florida	12,393	12,145	-4.3 <sup>a</sup>
Indiana	523	450	45.2 <sup>b</sup>
Kentucky	13,401	4,905	1.2
Minnesota	25,531	3,410	0.5
Missouri	4,656	3,983	-11.0 <sup>b</sup>
Ohio	425	499	-17.3 <sup>a</sup>
Texas	8,551	5,663	8.3 <sup>b</sup>
Wisconsin	2,339	1,695	16.1 <sup>a</sup>

SOURCE: Garfinkel et al. 1996.

<sup>a</sup> Significant at .05 level.

<sup>b</sup> Significant at .01 level.

NOTE: The effective sample size used in the fixed-effects model is roughly half of the total sample size listed here because roughly half of SELECT and non-SELECT enrollees had no prior utilization data.

This lack of information could be problematic for a number of reasons. First, research has shown that beneficiaries with secondary insurance use more health services than those with Medicare only (PPRC 1996). Consequently, the cost to Medicare of standard Medigap plans (SELECT or otherwise) might be understated if beneficiaries who bought such plans had prior supplemental coverage. Second, if low-cost SELECT policies induce beneficiaries who would not otherwise have bought supplemental coverage to do so, the estimates of SELECT's impact on Medicare costs could also be biased. Finally, the evaluation results could be biased if newly enrolled SELECT and non-SELECT beneficiaries had different patterns of prior enrollment in non-standard Medigap plans (and, consequently, different spending patterns).

The evaluation's mixed results could reflect either true differences in the effect of SELECT on Medicare's costs or methodological difficulties. For instance, only California and Florida had fairly large sample sizes in both the SELECT and non-SELECT groups (more than 10,000 beneficiaries in each sample).<sup>23</sup> Other states had significantly smaller sample sizes in at least one of the groups, which would tend to make it harder to identify a difference as statistically significant (Table 15-2). Besides the small initial sample sizes, researchers had no pre-enrollment utilization data for up to half of the

<sup>23</sup> Only California and Florida showed fairly consistent estimates of SELECT's cost effects when a variety of other statistical models were used.

beneficiaries in their sample populations, and, thus had to exclude them from the analysis.<sup>24</sup> As a result, the samples upon which the estimates of SELECT's effects on Medicare spending for the other nine states may have included fewer than 3,000 beneficiaries. Furthermore, when the evaluators looked at how demographic and health status factors affected per-beneficiary spending, their results differed from those found in other studies. For example, they failed to show higher expenditures for wealthier beneficiaries, a result shown in virtually every other analysis of Medicare spending.

The researchers suggested several explanations for the study's results. They suggested that not only is Medicare SELECT in an early stage of development, but it tends to be a weak form of managed care and may provide too few incentives for insurers to reduce costs (Garfinkel et al. 1996). That SELECT failed to reduce costs consistently may reflect the earlier cost experiences of new networks in general or result from several features of SELECT plans: many have hospital-only networks, few use gatekeepers or utilization controls, and the plans may not always use the most cost-effective providers (Garfinkel et al. 1996). Finally, because of SELECT insurers' limited liability for the costs of beneficiaries' care, it may cost them more to manage care strictly than simply to pay all submitted claims.

### **Data Reporting Requirements for Supplemental Insurers**

Problems stemming from the lack of data reporting requirements for supplemental insurers in the Medicare SELECT evaluation underscore the need for complete information upon which to base future studies. Because the researchers could not identify beneficiaries with prior supplemental coverage or obtain information about non-SELECT beneficiaries easily, they had to exclude large numbers of beneficiaries from the analysis. That may have biased the evaluation's results.

Instituting basic data reporting standards for supplemental insurers could alleviate this problem in the future and enable policymakers to better understand what supplemental insurance beneficiaries have and how that insurance affects Medicare expenditures. This type of reporting could also enhance the coordination of Medicare and supplemental health benefits. In some cases, information about beneficiaries' secondary insurance is already collected at the carrier level. The following sections describe those arrangements and a new system, which HCFA is developing, that should facilitate the collection of such information in the future.

**Current Arrangements.** Medicare carriers routinely obtain information about beneficiaries' supplemental insurance in two ways. The first is through automatic claims processing arrangements that many large Medigap insurers have negotiated with individual Medicare carriers. Under these crossover billing agreements, the Medicare carrier either forwards all eligible claims to the supplemental insurer for payment, or processes those claims on behalf of the supplemental payer. These arrangements typically lead to lower administrative and transaction costs for the insurer. They

---

<sup>24</sup> Because a fixed-effects model depends on the changes in per beneficiary average spending over time (i.e., before and after enrollment in a SELECT or non-SELECT Medigap plan), beneficiaries with no pre-enrollment utilization data cannot be included in analyses using the fixed-effects model.



also result in fewer problems for individual beneficiaries and ensure that all eligible Medigap claims are forwarded to the insurer. Although information on the number of beneficiaries covered by crossover billing agreements is not collected regularly, as many as 5 million beneficiaries may benefit from such arrangements.

Current law provides a second avenue for informing Medicare carriers routinely about Medicare beneficiaries' supplemental insurance coverage. Under certain conditions designed to facilitate the filing of beneficiaries' Medigap claims, Medicare carriers must file beneficiaries' Part B Medigap claims automatically.<sup>25</sup>

In both cases, carriers receive information about whether individual beneficiaries have secondary insurance coverage and the source of that coverage. Under the current system, however, this information is not routinely available to HCFA. The agency is developing a new administrative system with the capacity to collect such information regularly at the program level.

**The Medicare Transaction System.** HCFA is undertaking a major revision of its electronic claims processing and information management system. Called the Medicare Transaction System (MTS), it will change how HCFA administers and manages Medicare by creating a single, standardized repository for information about all aspects of the Medicare program. The system will handle fee-for-service Medicare program information, as well as data about Medicare managed-care plans, other Medicare coverage options, and beneficiaries' secondary insurance. It will integrate the information now contained in separate Part A, Part B, and managed-care files, and serve as the central administrative system for the entire Medicare program. The MTS will be implemented in three stages, starting later this year.

**The MTS and Secondary Insurance.** The MTS will collect information about Medicare beneficiaries' secondary insurance coverage on a voluntary basis, either through crossover billing agreements negotiated between supplemental insurers and Medicare carriers, or through mandated carrier filings of beneficiaries' supplemental claims. Despite the voluntary nature of the system, HCFA expects a large proportion of insurers (including self-insured employers) to enter into crossover billing agreements because of their potential to reduce insurers' claims processing costs and administrative hassles. HCFA is working with insurers to develop model agreements that should facilitate insurers' negotiations with carriers. For example, these agreements may enable multi-state insurers to negotiate a single crossover agreement with a centralized claims processor rather than having to negotiate individual processing contracts with as many as 79 different carriers, as they must currently do. Additionally, the standardization inherent in the MTS makes these agreements more attractive

---

<sup>25</sup> Medicare rules require Medicare carriers to file Medicare beneficiaries' Part B Medigap claims if three conditions are met: the service must be obtained from a provider who has signed a participation agreement with Medicare; the beneficiary must have a Medigap policy; and the beneficiary must indicate that he/she wants Medigap-covered payments to be made directly to the provider, and the provider must include this information on the Medicare claims form with the beneficiary's Medigap policy number.

because insurers will no longer have to adapt their administrative practices and systems to conform with each carrier's individual administrative and claims processing systems.

The MTS will be able to store certain specific information about beneficiaries' supplemental insurance. First, it will categorize supplemental insurance as standard Medigap, non-standard Medigap, or employer-provided retiree health insurance. Then it will further identify that insurance by policy number and insurer. In cases where a beneficiary has a standard Medigap policy, the MTS will record which plan (A-J) the beneficiary has purchased, whether it is a Medicare SELECT plan, and whether it was purchased as a group or an individual policy.

**Mandatory Data Reporting Standards.** In view of the importance and advantage of collecting data on beneficiaries' supplemental insurance status, reporting of such data should be mandatory. The new MTS will establish HCFA's ability and capacity to collect information about beneficiaries' supplemental insurance routinely. The Commission endorses the development of the MTS and suggests that the data be collected in a manner that is consistent with the capacity of the MTS to accommodate such information. Because of the costs and administrative burdens that mandatory requirements may impose on some insurers, these requirements should be phased in, in a fashion to be determined by HCFA. Furthermore, while some of the standardization of crossover billing agreements can proceed in the absence of the MTS, the Commission recognizes that the MTS will be crucial to HCFA's ability to collect this type of data regularly.

## **FUTURE COMMISSION WORK**

The Commission plans to continue to analyze the relationship between supplemental insurance and Medicare in the coming year. In addition to continued monitoring of the effects of secondary insurance on Medicare expenditures and the relationship between that insurance and beneficiaries' access to care, the Commission hopes to expand its analysis of employers' use of Medicare managed-care plans to provide supplemental benefits to Medicare-eligible retirees. It may also analyze the different types and combinations of supplemental benefits that Medicare beneficiaries receive as part of their Medigap or retiree health benefits, assessing their value to individuals and their effects on Medicare costs. As the Congress examines Medicare reform options, the Commission will evaluate how these proposals affect or are affected by supplemental insurance coverage. Finally, in 1996, the Commission presented alternative options to modify secondary insurance. It outlined one option—unified or full-replacement insurance—that would have addressed Medicare cost issues by requiring supplemental insurers to cover basic Medicare-covered services too. As the Congress considers the restructuring of Medicare, it may be appropriate to consider how this option would affect beneficiaries, insurers, and Medicare spending.

## REFERENCES

- Christensen, Sandra, Stephen H. Long, and Jack Rodgers, "Acute Health Care for the Aged Medicare Population: Overview and Policy Options," *The Millbank Quarterly* 65(3):397- 425, 1987.
- Chulis, George A., Franklin J. Eppig, Mary O. Hogan, et al., "Health Insurance and the Elderly: Data from MCBS," *Health Care Financing Review* 14(3):163-181, Spring 1993.
- Chulis, George, Franklin Eppig, and John Poisal, "Medicare and Private Health Insurance: Ownership and Average Premiums for Supplemental Policies," *Health Care Financing Review* 17(1):255-275, Fall 1995.
- Clark, Robert, and Juanita Kreps, "Employer-Provided Health Care Plans for Retirees," *Research on Aging* 11(2):206-224, June 1989.
- Clark, Robert L., Linda Shumaker Ghent, and Alvin E. Headen, Jr., "Retiree Health Insurance and Pension Coverage: Variations by Firm Characteristics," *Journal of Gerontology* 49(2):S53-S61, 1994.
- Families USA, *The Crushing Costs of Medicare Supplemental Policies* (Washington, DC: 1996).
- Foster Higgins, *National Survey of Employer-Sponsored Health Plans, 1994* (New York: 1995).
- Foster Higgins, *National Survey of Employer-Sponsored Health Plans, 1996* (New York: 1997).
- Fox, Peter D., Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* 20(1):31-48, Spring 1995.
- Garfinkel, Steven A., A. James Lee, Rezaul K. Khandker, et al., *Evaluation of the Medicare SELECT Amendments: Final Evaluation Report*, report to the Office of Research and Development, Health Care Financing Administration under Contract No. 500-93-0001 (Research Triangle Park, NC: Research Triangle Institute and Health Economics Research, Inc., February 1996).
- General Accounting Office, *Health Insurance for the Elderly: Owning Duplicate Policies is Costly and Unnecessary*, GAO/HEHS-94-185 (Washington, DC: August 1994).
- General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988-93*, GAO/HEHS-95-151 (Washington, DC: August 1995).
- General Accounting Office, *AARP Medigap Premium Increases, 1996*, GAO/HEHS-96-119R (Washington, DC: April 19, 1996a).



- General Accounting Office, *Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting*, GAO/HEHS-96-180 (Washington, DC: September 1996b).
- Grana, James, and Bruce Stuart, "The Impact of Insurance on Access to Physician Services for Elderly People with Arthritis," *Inquiry* 33(4):326-338, Winter 1996/97.
- Hay Group, *1996 Hay/Huggins Benefits Report*, Volume 1 (Philadelphia: Hay/Huggins, 1996).
- Health Care Financing Administration, Department of Health and Human Services, "Medicare: A Profile" (Washington, DC: February 1995a).
- Health Care Financing Administration, Department of Health and Human Services, "Fact Sheet: Medicare Insured Group (MIG) Demonstrations," working document, 1995b.
- Helms, David B., DuPont Company, oral statement before the Physician Payment Review Commission, May 2, 1996.
- Jensen, Gail, and Michael Morrissey, "Employer-Sponsored Postretirement Health Benefits: Not Your Mother's Medigap Plan," *The Gerontologist* 32(5):693-703, 1992.
- Lee, A. James, Steven A. Garfinkel, Rezaul K. Khandker, and Edward C. Norton, "The Impact of Medicare SELECT on Cost and Utilization," paper presented at the Association for Health Services Research Annual Meeting, June 11, 1996.
- Link, Charles R., Stephen H. Long, and Russell F. Settle, "Cost Sharing Supplementary Insurance and Health Services Utilization Among the Medicare Elderly," *Health Care Financing Review* 2(2):25-31, Fall 1980.
- Maher, Walter B., Chrysler Corporation, written statement to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 25, 1995.
- Maher, Walter B., Chrysler Corporation, oral statement before the Physician Payment Review Commission, May 2, 1996.
- McCall, Nelda, Thomas Rice, James Boismier, and Richard West, "Private Health Insurance and Medical Care Utilization: Evidence from the Medicare Population," *Inquiry* 28(3):276-287, Fall 1991.
- Morrissey, Michael A., "Retiree Health Benefits," *Annual Review of Public Health*, 14:271-292, 1993.

- Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series no. 7 (Washington, DC: Physician Payment Review Commission, November 1996).
- Pear, Robert, "Rates are Rising on Policies that Cover Gaps in Medicare" *New York Times* Dec. 20, 1995, A1 and B13.
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Prudential Insurance Company of America, personal communication, January 15, 1997a.
- Prudential Insurance Company of America, personal communication, February 27, 1997b.
- Romeo, John, personal communication, January 7, 1997 (Bethlehem Steel).
- Shea, Dennis G., and R. Patrick Stewart, "Ability to Pay for Retiree Health Benefits," *Inquiry* 31(2): 206-214, Summer 1994.
- Taylor, Amy K., Pamela Farley Short, and Constance Horgan, "Medigap Insurance: Friend or Foe in Reducing Medical Deficits?" in H.G. Frech III, ed., *Health Care in America* (San Francisco: Pacific Research Institute for Public Policy, 1988).
- Towers Perrin, *1995 Health Care Cost Survey: Report of Key Findings* (New York: February 1995).
- Weiss Ratings, *Medicare Supplement Price Survey: Your Personal Guide to Medicare Supplement Insurance in Your Area* (Palm Beach Gardens, FL: December 1995).





# The Changing Labor Market for Physicians

The Physician Payment Review Commission's interest in the changing labor market for physicians stems from two sources: its mandate to examine the supply and specialty mix of physicians, and its efforts to monitor changes in the market for health services and suggest to the Congress the implications of these changes for public policy.

Over the past 35 years, policymakers have returned periodically to issues surrounding the adequacy and competencies of the nation's health work force, focusing primarily on physicians. For many years, these debates were driven by concerns that an oversupply of physicians might undermine other efforts to bring health care costs under control, and that the nation was training relatively too many specialists and relatively too few physicians in primary care (defined as family practice, general internal medicine, and general pediatrics). (Obstetrics-gynecology is not considered a primary care field for the purposes of this chapter.) A variety of federal policies have been proposed and implemented to address these concerns.

More recently, changes in the health care marketplace have created a new context for considering these concerns. Some argue that the problems of physician oversupply and specialty imbalance are among those that will be resolved by a competitive health care market. In theory, the growth of cost-conscious integrated health systems will alter the number and mix of services used by patients and thus the number and mix of health professionals needed to provide those services. These developments will in turn result in physicians being employed at greatly reduced compensation or being unable to find jobs in medicine, thus sending a signal to students and educators to

*This chapter includes:*

- *Changes in the market for health services that affect the physician work force*
- *Signals of change in physician specialty mix*
- *Signs of changes in demand for physicians overall*
- *Changes in physician employment arrangements*

change. Others doubt that market forces will lead to significant change and continue to call for direct action by policymakers, educators, and payers to address concerns about supply and specialty mix. An argument can also be made that market forces cannot be expected to work, given the substantial federal subsidies for physician training.

In its 1995 and 1996 annual reports, the Commission examined whether changes in the organization and financing of health care were affecting the labor market for physicians. Two types of change in the labor market were assessed: whether there was evidence that increasing demand for primary care physicians was leading to changes in specialty mix, and whether there was any indication that the market was creating incentives to train fewer physicians overall. In last year's report, the Commission noted that the physician labor market was indeed changing, but that these changes, as captured through systematic data, were more modest than suggested by anecdotes.

In this report, the Commission once again considers the available empirical data to determine whether specialty mix and physician supply are changing. This year, the signals are ambiguous. While there are some signs that specialty mix may be changing in response to market demand for primary care physicians, there are also signs of continued strong demand for physicians in highly specialized fields. In addition, despite common beliefs to the contrary, many indicators do not reflect an oversupply of physicians. Finally, changes in the market appear to be affecting the conditions of employment for many physicians.<sup>1</sup>

## **MARKETS RELEVANT TO THE PHYSICIAN WORK FORCE**

In considering whether changes in the market for health services will influence shifts in physician supply and specialty distribution, it is important to recognize that there are actually two markets of interest: the market for physicians' services and the market for physician training. This distinction matters for two reasons. First, market pressures may lead to diametrically opposed responses from the two markets. Although organized systems of care may be demanding fewer physicians and relatively more primary care physicians than in the past, teaching hospitals, under significant pressure to economize, may be more dependent than ever on using residents to meet service needs. Moreover, even if graduates of U.S. medical schools begin to respond to market pressures by increasingly seeking positions in primary care fields, hospitals may continue to meet their staffing requirements by filling positions with international medical graduates (IMGs).

Second, notwithstanding substantial changes in the market for physicians' services, the length of the training pipeline and the large stock of practicing physicians will preclude any substantial short-run impact on supply and specialty mix. For example, a large increase in starting salaries for primary care physicians will not likely affect the behavior of individuals who have just begun training in surgical

---

<sup>1</sup> This chapter does not consider the impact of market changes on the geographic distribution of practicing physicians or the demographic composition of the physician work force.

specialties. As a result, one would expect that indicators measuring the production of physicians would lag behind those measuring changes in the practice environment. Furthermore, given the size of the pool of practicing physicians, even substantial changes in the behavior of recent graduates will have only a small effect on the size and composition of the physician work force.

Data are presented in this chapter that describe both of these markets. For example, data on the number and mix of residents are indicative of changes in the market for training. Data on physician incomes and practice arrangements are relevant to changes in the market for physicians' services.

## **CHANGES IN THE SPECIALTY MIX OF PHYSICIANS**

There are several indicators of potential changes in the mix of physicians in different specialties: relative incomes, the availability of jobs, and medical students' expressed specialty preferences. These indicators, reviewed below, suggest a moderate trend toward generalism.

In previous reports, the Commission also examined data from the annual residency match to consider whether there were changes in the types of residency positions sought by graduating medical students. Because of the difficulty in interpreting these data, the Commission has not included them in this report.<sup>2</sup>

### **Changes in Relative Incomes**

The Commission noted that in 1994 physician incomes had fallen for the first time since the American Medical Association (AMA) began collecting these data. In 1995, median physician income rebounded, rising about 3.8 percent (Table 16-1). The two-year trend, however, shows a loss of about 2.5 percent. As a result, real median incomes remain below those for 1993 (Mitka 1997). Analysis of this series through 1994 found the decline in physician earnings was directly (although weakly) associated with an increase in managed-care penetration (Simon and Born 1996).

Although most specialties experienced income increases in 1995, patterns of income changes differed somewhat across specialties. Moreover, the patterns are not consistent within specialty groups (e.g., primary care, surgery). For example, while incomes of family practitioners and pediatricians are at a new high, median incomes for internists continue to drop. Median incomes across all physician specialties continue to remain far apart, however, at \$250,000 for orthopedic surgeons and \$124,000 for those in family practice.<sup>3</sup>

---

<sup>2</sup> Data from the resident match can be difficult to interpret as indicators of labor market change for several reasons. First, the number of positions that happen to be offered through the match varies annually. Second, because it is geared to graduating medical students, the match does not encompass those fields that are entered in later years (for example, training in internal medicine subspecialties begins after completion of a residency in internal medicine).

<sup>3</sup> Expectations about starting salaries are another potential barometer of income shifts between generalists and specialists. Regrettably, the annual survey on physicians' expectations about starting salaries that the Commission had included in previous reports is no longer available because the firm that conducted it, Physician Services of America, has gone out of business.



**Table 16-1. Real Median Physician Income, by Selected Specialties and Years**  
(1995 dollars in thousands)

Specialty	1981	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	\$118	\$107	\$107	\$108	\$108	\$115	\$113	\$124
Internal medicine	139	139	138	138	140	157	154	150
Pediatrics	106	106	115	116	121	126	113	129
Surgery								
General surgery	194	213	196	188	194	236	226	225
Ophthalmology	*	*	202	221	188	191	180	194
Orthopedics	*	*	311	259	269	283	279	250
Other Specialties								
Anesthesiology	194	192	230	232	237	231	205	203
Obstetrics-gynecology	181	169	212	221	204	210	187	200
Psychiatry	116	122	123	122	129	126	123	124
Radiology	191	207	230	247	258	252	226	230
All Specialties	152	155	150	154	159	164	154	160

SOURCE: American Medical Association Socioeconomic Monitoring System.

\* Not available.

NOTES: Values have been adjusted for inflation using the gross domestic product deflator.

Incomes are revenues net of expenses.

### Changes in Jobs Available by Specialty

Many expect the growth of managed-care organizations to result in more job opportunities for primary care physicians and fewer positions for specialists. The one longitudinal source of information on the availability of jobs in different fields is an AMA survey of residency program directors concerning the employment experience of their recent graduates, their perceptions about the difficulties graduates have in getting jobs (particularly in clinical practice), and actions they are taking at the program level to respond to those issues. This survey was conducted for the first time in 1994 and has since been repeated. In 1995, physicians in generalist fields were once again reported to have less difficulty finding positions than those in specialties (AMA 1997). For example, fewer than 1 percent of those in family practice reported difficulty finding full-time clinical positions compared with 15.8 percent of trainees in anesthesiology, 20.7 percent in gastroenterology, and 14.9 percent in ophthalmology. Overall, the percentage of residents having difficulty increased from 6.3 percent to 6.9 percent. The trend varied substantially across fields, however. Residents in a number of fields had less difficulty finding a job in 1995; these included family practice, anesthesiology, cardiology, and plastic surgery. Others had more difficulty, including residents in internal medicine, pediatrics, general surgery, obstetrics-gynecology, and ophthalmology. It is unclear whether changes in rates reflect true differences in job availability or altered perceptions about how hard it will be to find a full-time clinical position (AMA 1997).

A survey of training outcomes by the American College of Cardiology also suggests that specialists continue to be able to find jobs. Fully 98 percent of those surveyed had obtained a post-training position. While about half found the job search to be very or somewhat difficult, 42 percent found the search very or somewhat easy (American College of Cardiology 1996).<sup>4</sup>

### Changes in Medical Students' Expressed Career Preferences

Among the indicators of changes in specialty mix, the plans of graduating allopathic medical students show a continued strong trend toward generalism (Table 16-2). Almost 32 percent of graduating allopathic medical students now indicate they are interested in primary care fields, more than double the share just five years ago. And for the first time, interest in primary care exceeds the level in 1980 when it first started to drop. Interest in primary care has traditionally been higher among osteopathic medical students; in 1995, 43 percent selected primary care as a career, the same as in 1982 (AOA/AACOM 1997).

Among allopathic students, anesthesiology and radiology continue to drop in popularity; only 1 percent of medical school seniors expressed interest in anesthesiology as a career, compared to 7 percent in 1991 (AAMC 1996a).

**Table 16-2. Graduating Allopathic Medical Students' Career Preferences, by Selected Specialties and Years, 1980-1996 (percentage)**

Specialty	1980	1985	1991	1992	1993	1994	1995	1996
Primary Care	31.0%	29.8%	14.9%	14.6%	19.3%	22.8%	27.6%	31.9%
Family practice	14.5	13.3	9.4	9.0	11.8	13.1	15.7	16.6
Internal medicine	10.6	10.7	2.9	3.2	4.5	6.2	7.7	9.7
Pediatrics	5.9	5.8	2.6	2.4	3.0	3.5	4.2	5.6
Surgery								
General surgery	4.8	6.2	2.1	2.1	2.1	3.0	3.4	3.8
Ophthalmology	3.5	3.6	3.4	3.4	3.2	3.4	3.0	2.7
Orthopedics	4.8	5.7	4.7	5.3	4.8	5.0	4.5	4.1
Other Specialties								
Anesthesiology	2.3	5.7	7.0	6.8	5.7	4.7	2.9	1.0
Medical subspecialties	3.7	10.6	16.0	16.4	14.2	12.2	12.0	11.0
Obstetrics-gynecology	4.2	5.4	2.5	2.7	3.1	3.8	4.0	4.5
Psychiatry	2.8	4.2	2.1	1.6	1.5	2.0	2.2	1.3
Radiology	3.8	5.7	7.7	7.2	7.3	6.6	6.7	4.2

SOURCE: 1980-1996 Association of American Medical Colleges Medical School Graduation Questionnaire.

NOTE: Percentages based only on students who had decided on a specialty. Data since 1991 based on slightly different question format.

<sup>4</sup> Some 8 percent had no opinion or did not conduct a job search.

## Changes in the Mix of Residency Positions and Programs

Another measure of potential changes in specialty mix is the mix of first-year residents (Table 16-3). Here there is also a trend toward generalism, although the shift is less dramatic than that for the survey of medical student career preferences. In 1995, the share of first-year residents in primary care fields rose slightly from 57 percent to 59 percent, the same level as in 1993. Specialties such as obstetrics-gynecology and orthopedics experienced slight losses.<sup>5</sup> Although graduates of osteopathic medical schools have traditionally been more primary-care oriented, adding osteopathic residents in osteopathic programs to the count of trainees in allopathic programs does not substantially change the percentage in any field because of their relatively small numbers.

**Table 16-3. Distribution of First-Year Residents, by Selected Specialties and Years, 1980-1995 (percentage)**

Specialty	1980	1986	1990	1993	1994	1995
Primary Care	54%	57%	57%	59%	57%	59%
Family practice	13	13	11	12	13	13
Internal medicine	32	34	36	36	34	35
Pediatrics	10	11	11	11	10	11
Surgery						
General surgery	14	13	13	12	12	12
Orthopedics	1	1	1	2	2	1
Other Specialties						
Anesthesiology	3	2	2	1	1	1
Obstetrics-gynecology	7	6	5	5	6	5
Pathology	3	2	2	2	2	2
Psychiatry	6	5	5	5	5	5
Radiology	2	1	2	2	2	2

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

NOTES: Percentages do not add to 100 because some specialties are not displayed.

Includes osteopathic graduates in allopathic programs.

## CHANGING DEMAND FOR PHYSICIANS

In its 1996 report, the Commission noted that both the market for physicians' services and the market for training appeared to be signaling that there are too many physicians overall. This year, the evidence is less clear. Physician incomes (aggregated across all specialties) and the number of first-year and

---

<sup>5</sup> The number of residents in some specialized fields such as anesthesiology is so small relative to the total number of residents that only massive changes would affect the specialty's share of first-year residents.



total residents continue to grow, although at lower rates than in the past. In addition, the number of residency programs is still climbing, although quite slowly in most fields except for family practice.

The number of first-year residents increased between 1980 and 1990, with particularly large growth in 1993. After returning to historical levels in 1994, these figures rose again in 1995 to 21,372 (nearly 11 percent) (Table 16-4). The number of first-year residents grew in every specialty tracked by the Commission with three exceptions: anesthesiology, obstetrics-gynecology, and orthopedic surgery. The overall increase cannot be attributed to international medical graduates. After reaching nearly 7,000, or 36 percent of first-year residents, in 1994, the number of first-year residents graduating from foreign medical schools fell to about 5,300 (25 percent) in 1995 (Table 16-5). The specialty distribution of international medical graduates has changed somewhat since 1990, with a mounting share of IMGs in anesthesiology, internal medicine, pathology, pediatrics, and psychiatry (Table 16-6).

**Table 16-4. First-Year Residents, by Selected Specialties and Years, 1980-1995**

Specialty	1980	1986 <sup>a</sup>	1990	1993	1994	1995
Primary Care						
Family practice	2,371	2,281	1,934	2,503	2,512	2,792
Internal medicine	5,948	6,234	6,518	7,843	6,524	7,502
Pediatrics	1,864	1,938	1,937	2,454	1,999	2,273
Surgery						
General surgery	2,539	2,412	2,408	2,567	2,384	2,483
Ophthalmology	<sup>b</sup>	<sup>b</sup>	<sup>b</sup>	<sup>b</sup>	<sup>b</sup>	<sup>b</sup>
Orthopedics	218	257	269	353	311	300
Other Specialties						
Anesthesiology	523	325	358	314	258	207
Obstetrics-gynecology	1,220	1,048	1,000	1,121	1,097	1,087
Pathology	642	415	449	538	388	513
Psychiatry	1,063	980	874	1,096	899	1,010
Radiology	409	257	376	430	420	434
All Specialties	18,702	18,183	18,322	21,616	19,293	21,372

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

<sup>a</sup> Data from 1985 are not available.

<sup>b</sup> Residents may not enter training in ophthalmology in their first postgraduate year.

NOTE: Includes osteopathic graduates in allopathic programs.

**Table 16-5. Trends in the Number and Percentage of Residents Who Are International Medical Graduates, by Selected Years, 1970-1995**

Year	Total Number of Residents		Percentage Who Are International Medical Graduates	
	First-Year	All	First-Year	All
1970	11,552	39,463	29%	33%
1975	11,401	54,500	29	31
1980	18,702	61,465	21	20
1985	19,168	75,514	14	17
1990	18,322	82,902	19	18
1991	19,497	86,217	24	20
1992	19,794	89,368	25	20
1993	21,616	97,370	27	23
1994	19,293	97,832	36	24
1995	21,372	98,035	25	25

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

**Table 16-6. Shares of Total Residents Who Are International Medical Graduates, by Selected Specialties and Years, 1990-1995 (percentage)**

	1990	1991	1992	1993	1994	1995
Primary Care						
Family practice	14.8%	16.1%	18.7%	19.7%	17.9%	16.7%
Internal medicine	28.6	34.1	36.4	39.6	41.9	42.5
Pediatrics	31.4	33.1	33.3	33.6	32.1	50.6
Surgery						
General surgery	8.5	9.0	*	10.8	11.4	11.7
Ophthalmology	3.7	4.6	4.9	6.5	6.6	6.9
Orthopedics	1.3	1.3	1.2	1.2	1.4	1.7
Other Specialties						
Anesthesiology	11.5	12.8	14.3	16.1	19.9	24.4
Obstetrics-gynecology	8.0	7.4	7.1	6.1	5.8	6.1
Pathology	28.1	28.7	29.6	30.3	30.4	33.8
Psychiatry	21.0	23.0	25.2	32.8	36.1	41.4
Radiology	3.8	3.9	4.1	4.7	4.9	5.6
All Specialties	18.0	20.0	20.0	23.3	24.0	25.5

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

\* Data not available.

A third indicator of the size of the graduate medical education enterprise is the total number of residents (Table 16-7) and training programs (Table 16-8). In 1995, allopathic programs grew 4 percent as the result of increases in most major specialties. The number of residents per program dropped in several specialized fields, among them anesthesiology (with 58 percent of programs becoming smaller during the 1994-1995 academic year), cardiology (30 percent) and gastroenterology

(25 percent). Fewer than 1 percent of programs in family medicine decreased the number of residents (AMA 1997).

**Table 16-7. Total Residents, by Selected Specialties and Years, 1980-1995**

Specialty	1980	1986*	1990	1993	1994	1995
Primary Care						
Family practice	6,344	7,238	6,680	7,976	8,587	9,261
Internal medicine	15,964	18,116	18,734	20,603	20,693	21,071
Pediatrics	5,171	5,817	6,115	7,460	7,394	7,354
Surgery						
General surgery	7,440	7,880	7,644	8,243	8,217	8,221
Ophthalmology	1,480	1,549	1,446	1,674	1,611	1,602
Orthopedics	2,418	2,822	2,630	3,029	2,903	2,872
Other Specialties						
Anesthesiology	2,490	3,864	4,889	5,696	5,490	4,861
Obstetrics-gynecology	4,221	4,525	4,315	5,074	5,046	5,007
Pathology	2,186	2,299	2,364	2,731	2,766	2,788
Psychiatry	3,911	4,892	4,673	5,044	4,979	4,919
Radiology	2,766	3,095	3,775	4,236	4,189	4,090
All Specialties	62,853	76,815	82,902	97,370	97,832	98,035

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

\* Data from 1985 are not available.

NOTE: Includes osteopathic graduates in allopathic programs.

**Table 16-8. Number of Allopathic Residency Programs, by Selected Specialties and Years, 1979-1995**

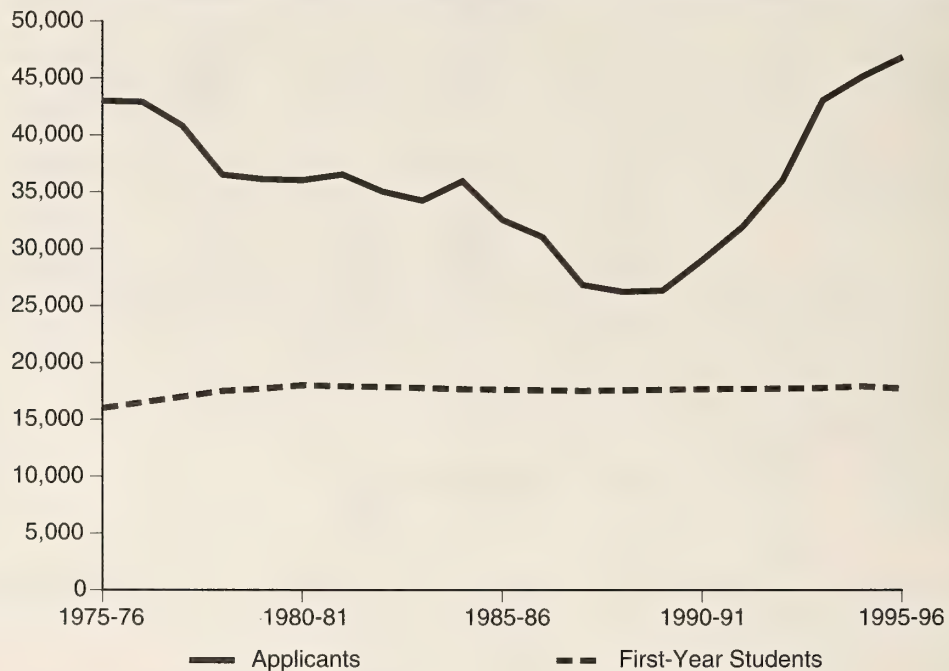
Specialty	1979	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	385	385	383	393	395	407	430	455
Internal medicine	443	442	426	427	418	416	415	416
Pediatrics	245	236	215	217	214	215	215	215
Surgery								
General surgery	331	306	281	281	270	270	271	269
Ophthalmology	155	142	136	137	135	135	137	137
Orthopedics	180	168	163	161	161	161	160	158
Other Specialties								
Anesthesiology	161	165	155	157	155	155	149	154
Obstetrics-gynecology	304	292	275	273	273	274	273	272
Pathology	358	261	217	195	192	188	186	185
Psychiatry	223	211	196	200	197	198	196	201
Radiology	221	211	210	210	206	205	206	206
All Specialties	4,742	4,799	6,938	7,189	7,065	7,277	7,347	7,657

SOURCE: *Journal of the American Medical Association Medical Education Issues.*



Changes in college students' willingness to pursue medical careers might be a lagging indicator of a tightened labor market for physicians. To date, however, there is no evidence that shifts in the organization and delivery of medical care are discouraging college students from becoming physicians. For the 1995-1996 school year, the number of allopathic medical school applications rose to an all-time high of 46,591, up about 3 percent from the prior year (Barzansky et al. 1996; AAMC 1996b). Medical school enrollment has remained relatively flat over the past 20 years (Figure 16-1). The 10,781 applicants to osteopathic schools in 1995 represented an increase of 5 percent over the prior year (AOA/AACOM 1997).

**Figure 16-1. Applicants and First-Year Enrollment in U.S. Medical Schools, 1975-1995**



SOURCE: Barzansky et al. 1996; AAMC 1996b.

As an indicator of change in the labor market for physicians, growth in the number of applications to medical school should be interpreted with caution, however. That is because employment prospects in other fields also influence students' willingness to apply to medical school. Uncertainty about future prospects in law, business, engineering, and other professional fields thus may contribute to students' growing interest in medical careers. A downturn in the labor market for lawyers has led to fewer law school applicants. Since 1990, the number of people taking the law school entrance exam has dropped by one-third, and about 50 of the nation's 180 accredited law schools have reduced class size in recent years (Chandrasekaran 1996).

Other changes, such as the number of physicians taking early retirement or relocating, might also be indicators of response to shrinking opportunities for physicians. While there is considerable anecdotal evidence that physicians are retiring, moving, and becoming more dissatisfied with their careers, there

continue to be no good data sources to track these factors.<sup>6</sup> Similarly, changes in the roles of nonphysician practitioners who provide primary care services (for example, nurse practitioners and physician assistants) might also signal an oversupply of physicians. Such changes are more difficult to measure, however, and may be confounded by current restrictions on payment and practice, as well as by the varying roles that these practitioners play in managed-care organizations.

## **CHANGING TERMS OF EMPLOYMENT**

Changes in the market for health services may have another effect on the labor market for physicians—namely, the terms of employment or types of practice arrangements available to new physicians. In 1995, the share of physicians who are employees increased to 39 percent, up from 36 percent in 1994. At the same time, the share of self-employed physicians dropped to 55 percent from 58 percent (Mitka 1996). Union membership has also grown dramatically among physicians, although union members still account for a small share (less than 10 percent) of the nation's practicing physicians (Worcester 1996).

A related trend is the growth in salaried positions rather than offers of income guarantees or other forms of compensation. Merritt, Hawkins and Associates, a national physician recruitment firm, reports that 63 percent of the job searches it conducted between April 1995 and April 1996 were for salaried positions, compared with just 44 percent the year before (Kostreski 1996).

## **CONCLUSIONS**

The evolving market for health services appears to be changing the national labor market for physicians. The lack of data at the market level precludes our ability to determine whether these changes are more pronounced in the most competitive markets. National data indicate that positions in generalist fields are becoming somewhat more attractive but that changes in relative incomes have been modest. Overall job opportunities for physicians, however, do not appear to be contracting. The changing market does appear to be affecting physicians' practice arrangements, with an increasing share of physicians becoming employees rather than being self-employed or holding equity in a group practice.

---

<sup>6</sup> Changes in the average retirement age can be obtained from the AMA's Physician Masterfile, but these calculations are not made regularly.

## REFERENCES

- American College of Cardiology, *Training Outcomes Survey* (Bethesda, MD: 1996).
- American Medical Association, "Difficulty Experienced by Resident Physicians Who Secured a Clinical Practice Position," unpublished table, February 1997.
- American Osteopathic Association and American Association of Colleges of Medicine, letter to the Physician Payment Review Commission, February 26, 1997.
- Association of American Medical Colleges, Medical School Graduation Questionnaire, "Specialty and Subspecialty Certification Plans of Graduating Medical Students, 1985 to 1996," unpublished table, 1996a.
- Association of American Medical Colleges, personal communication to the Physician Payment Review Commission, October 9, 1996b.
- Barzansky, Barbara, Harry S. Jonas, and Sylvia I. Etzell, "Educational Programs in U.S. Medical Schools, 1995-1996," *Journal of the American Medical Association* 276(9):714-719, September 4, 1996.
- Chandrasekaran, Rajiv, "Where the Jobs Aren't. Lawyers Losing Positions, Facing Pay Cut as Large Corporations Shrink Costs," *Washington Post*, October 11, 1996, p.A-1.
- Kostreski, Farah, "More Physicians Being Offered Salaried Positions: Income Guarantees Declining," *Internal Medicine News*, August 15, 1996, p.46.
- Mitka, Mike, "Physician Pay Back Up, But Two-year Trend Still Shows Loss," *American Medical News*, January 6, 1997, p.1.
- Simon, Carol J., and Patricia H. Born, "Physician Earnings in a Changing Managed Care Environment," *Health Affairs* 15(1):124-133, Fall 1996.
- Worcester, Sharon, "Managed Care Pushing More Doctors into Unions," *Internal Medicine News*, November 15, 1996, p.68.



# Academic Medical Centers and the Changing Health Care Marketplace

Traditionally, academic medical centers (AMCs) have supported their unique social missions—education of health professionals, biomedical research, and uncompensated care—through a complex system of cross-subsidies. This method of financing may no longer be tenable, however, as managed-care plans are less willing than indemnity insurers to pay higher fees for care in academic settings, and budget crises at the local, state, and federal levels pose threats to government support.

Academic medical centers are responding to these changes in several ways. First, many are making significant changes in their operations to increase their efficiency and secure market share. Second, they are communicating their concerns about the future to policymakers at the federal and state levels in an effort to sustain or expand government support.

This chapter considers what is known about the effect of market change on academic medical centers and how these centers are responding. The Physician Payment Review Commission's work in this area has been informed by its broader efforts to understand and monitor the impact of marketplace change on providers, payers, and consumers. In addition, the Commission brings to this issue its expertise concerning the financing of graduate medical education.

In the Commission's view, academic medical centers are not now so disadvantaged by changes in the market as to warrant special action by federal policymakers. Yet because of the unique roles these institutions play in providing patient care, conducting research, and educating health professionals, it will be important to continue monitoring how market changes are affecting them in case circumstances begin to change.

*This chapter considers:*

- *The structure and financing of academic medical centers*
- *What is known about how changes in the market for health services are affecting academic medical centers*
- *How academic medical centers are responding*
- *Current research efforts exploring these issues*

The chapter begins by describing the structure of academic medical centers and how they are financed. Subsequent sections consider how academic centers are faring as the health care marketplace evolves, what strategies are being used to respond to changes in the market, and research efforts under way on these issues.

## **STRUCTURE AND FINANCING**

The term, academic medical center, refers to a group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professions schools.<sup>1</sup> This definition is somewhat misleading, however, because it suggests a homogeneous group when, in fact, there are many differences across centers in how each center's member institutions are structured and how they relate to one another operationally and financially. These differences are important to consider because they may affect the strategies AMC's can pursue to compete in the marketplace. But there are commonalities in roles and responsibilities. This section describes the institutions that make up AMC's, the functions they perform, how they relate to one another, and how they are financed.

### **Medical Schools**

In addition to enrolling and educating undergraduate medical students, medical schools fulfill several roles within the AMC. These include hiring faculty, setting faculty base salary amounts and bonuses, granting tenure, operating a medical library, providing facilities for research, and performing a number of basic administrative functions (Reuter 1996).<sup>2</sup>

Medical schools are financed by a variety of sources, the most important being clinical income (Figure 17-1). Together, revenues from faculty practice plans and hospital programs constitute 47 percent of allopathic medical school revenues.<sup>3</sup> This represents a marked change from 30 years ago when clinical practice income accounted for less than 5 percent of medical school revenues and government support accounted for over 70 percent (Figure 17-2) (Ginzberg et al. 1993). Osteopathic medical schools rely less heavily on clinical income (17.2 percent of revenues) and more so on revenues from tuition and fees (40.9 percent of revenues) (AOA/AACOM 1997).

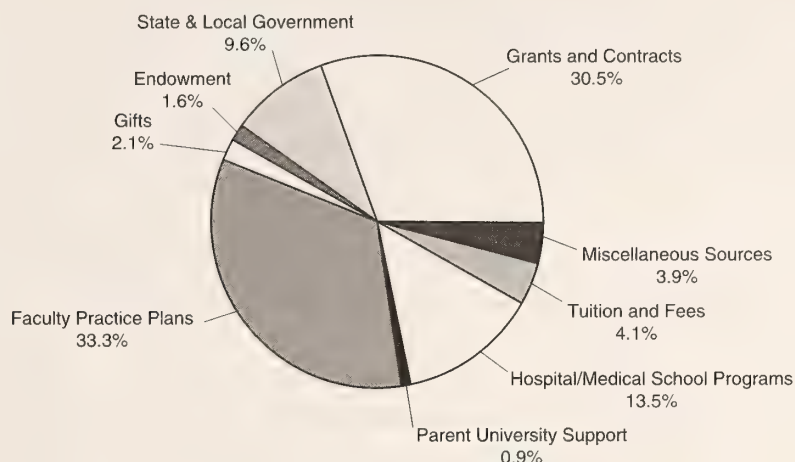
---

<sup>1</sup> There are disagreements on how to count academic medical centers. There are 125 allopathic medical schools in the United States; these have arrangements with one or more teaching hospitals. Teaching hospitals are those hospitals with at least one resident in an approved training program. There are about 1,000 teaching hospitals nationwide. Osteopathic consortia can also be considered academic medical centers because they include a teaching hospital, a medical school, and faculty practice plans.

<sup>2</sup> Some of these functions, such as granting tenure and operating a library, may reside at the university level.

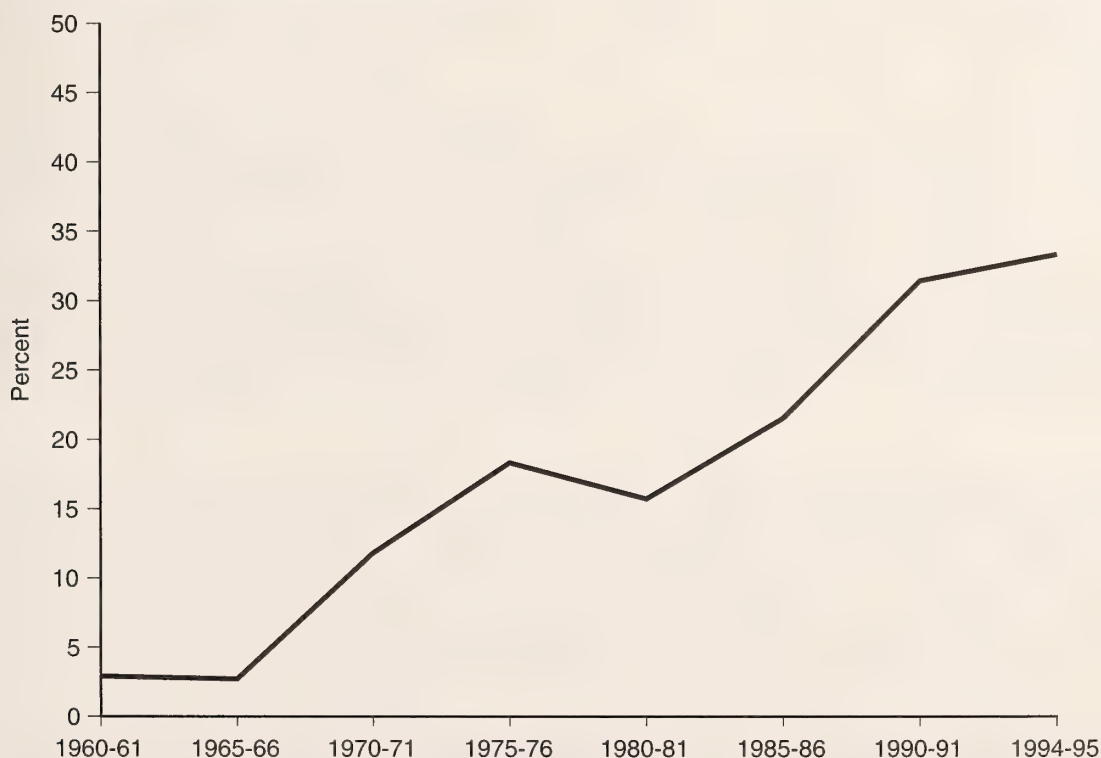
<sup>3</sup> This figure does not differ much between public medical schools (44.9 percent) and private medical schools (48.8 percent). Private freestanding schools are the most dependent on practice plan income (57 percent of revenues).

**Figure 17-1. Composition of Revenues of U.S. Allopathic Medical Schools, 1994–1995 (percentage)**



SOURCE: Association of American Medical Colleges 1996.

**Figure 17-2. Share of U.S. Allopathic Medical School Revenues from Faculty Practice Plans, 1960–1995 (percentage)**



SOURCE: Association of American Medical Colleges 1996.



The flow of revenues from patient care activities to the medical school illustrates the complexity of AMC financing. Part of the transfer of practice plan revenues to medical schools does not involve shifting actual money. For example, the practice plan may simply pick up a portion of faculty salaries. But the medical school also obtains a percentage of clinical service income. Schools have idiosyncratic methods of calculating this so-called dean's tax. The tax ranges between 5 percent and 20 percent of service income, and may be based on a fixed percentage of gross revenues, or a percentage of revenues net of expenses including the plan's share of faculty compensation (Reuter 1996; Fox and Wasserman 1993).

Over the past three years, total real revenues of medical schools have grown about 4 percent to 6 percent annually. These are low increases by historical standards; over the past 15 years, the average annual increase has been 11.8 percent (Reuter 1996). In fact, the gain of 4.1 percent between the 1993-1994 and 1994-1995 academic years was the second smallest inflation-adjusted gain since these data were first reported in the *Journal of the American Medical Association* in 1960 (Krakower et al. 1996).<sup>4</sup>

Differences in medical schools' structure and governance can influence how they are affected by and respond to market change. First, the relationships between schools and their training sites may affect the AMC's options for positioning itself in a local market and the speed with which it can make internal changes. In the traditional allopathic model, a medical school is part of a large research university; it either owns a large teaching hospital or has a long-standing relationship with one or more large teaching hospitals with joint appointments of medical school department chairs and hospital chiefs of service.

Community-based medical schools, such as East Virginia and Michigan State, are also part of a university but use community hospitals as the principal site for teaching with both full-time and community physicians serving as faculty. Osteopathic medical schools are more similar to this model because of their focus on patient care, rather than on research. Some schools, such as the University of South Carolina and Texas A&M, use a Department of Veterans Affairs (VA) hospital as their chief clinical training site (Jones 1992). In addition, 14 allopathic schools and 4 osteopathic schools are freestanding educational institutions, not connected to a parent university (Reuter 1996; AOA/AACOM 1997).

Second, while both public and private institutions have commitments to producing social goods, differences in governance can affect the ability of academic medical centers to finance them. Currently, 51 allopathic medical schools are private; 74 are public. Among the 17 colleges of osteopathic medicine, a larger share is public, with 6 private and 11 public schools.

---

<sup>4</sup> Krakower and his colleagues note that the smallest gain was between 1979-1980 and 1980-1981 but do not provide its value.

The distinction between public and private may matter for several reasons. First, all AMCs need capital to compete, for example, to purchase information systems or physician practices. While private schools may not have substantial operating surpluses, public schools may be disadvantaged in securing capital because they are typically required to return any operating surpluses to the state treasury (Blumenthal and Meyer 1996; Iglehart 1995b).<sup>5</sup> Second, public institutions may also be required to seek approval from the state board of regents or state legislature for contracts with health plans or new affiliations with training sites. State legislators may be particularly concerned about arrangements under which a public institution accepts insurance risk (Ball and Rubin 1995). Some public schools, such as Oregon Health Sciences University, are becoming public corporations to avoid oversight from state educational authorities (AMA 1997).

## **Faculty Practice Plans**

Most faculty practice plans were originally organized for the purpose of billing, collecting, and distributing the professional fees of medical school faculty. More recently, these organizations have taken on new roles, including organizing the delivery of medical care within the AMC, constructing facilities (especially ambulatory care centers), negotiating contracts with managed-care plans, and joining with hospitals to contract directly with purchasers (Jones 1992; Culbertson 1996).

Total practice plan revenues for allopathic medical schools amounted to \$9.7 billion in the 1994-1995 academic year. Although revenues grew 4.5 percent in real terms over the previous year, this increase was below the 10-year average of 6.9 percent (Reuter 1996). Declines in real practice plan revenues were reported by 26 schools, and nearly half of schools experienced real declines in practice plan revenues per faculty member.<sup>6</sup> Among medical schools in areas with high managed-care penetration, practice plan revenues per faculty member have been declining since 1991. Among schools located in low penetration areas, the revenue trend has been relatively constant (AAMC 1996b).

The distribution of revenues within the practice plan can be as complex as the flow of revenues throughout the academic medical center. Revenues (net of the dean's tax and administrative expenses) may be distributed to individual faculty either via salaries or payments of base amounts with bonuses based on productivity.<sup>7</sup> In some plans, departments cross-subsidize each other; in others, each department must generate its own support (Fox and Wasserman 1993).

There are at least two dimensions to practice plans' structure that may affect their ability to respond to market forces. Legally, practice plans may be set up as independent professional corporations or nonprofit corporations. About half are associations or divisions within the university. Organizationally,

---

<sup>5</sup> As an example, in the early 1990s, the California legislature directed the state's five university teaching hospitals to transfer surpluses and incur debts of \$43 million to support other university activities. In addition, state support of these institutions was cut by \$15 million (Iglehart 1995b).

<sup>6</sup> The number of clinical faculty has grown markedly over the past ten years, increasing from 47,193 to 73,419.

<sup>7</sup> The compensation method can also vary from department to department.

there may be as many practice plans as there are clinical departments, or there may be a centralized plan with one governing board and a centralized administrative structure (essentially a multispecialty group practice). Some plans use a federated model in which departmental practice arrangements have some common governance and management (for example, shared support services) (Jones 1992; Reuter 1996).

A number of AMCs are reorganizing their practice plans both to facilitate contracting with managed-care plans and to reduce costs.<sup>8</sup> Moreover, several AMCs, including St. Louis University and the University of Michigan, have merged the faculty practice plan and university hospital into integrated delivery systems in an effort to unify and focus decisionmaking, as well as to improve operational efficiency (Dickler and Fishman 1996).

### **Teaching Hospitals**

Within the AMC, teaching hospitals serve as the primary site for patient care, training of medical students and residents, and the conduct of clinical research. Hospitals typically pay the salaries and benefits of residents, and they may pay a portion of faculty salaries for services provided to the hospital.

Academic medical center hospitals vary in their ownership and the type of affiliation they have with a medical school. In an American Medical Association (AMA) survey of medical schools to determine what types of hospitals were used as inpatient sites for required clinical clerkships, 76 percent used nonprofit private hospitals; 75 percent used federal hospitals (either those owned by the Departments of Veterans Affairs or Defense); 55 percent used a medical school or university-owned hospital; 53 percent used public city, county, or state hospitals; and 22 percent used for-profit, private hospitals.<sup>9</sup>

Teaching hospitals are financed by a variety of sources, the most important being those attributable to patient care (90.4 percent of revenues) (Reuter 1996). A small but important source of revenue is Medicare payment for the costs of graduate medical education.<sup>10</sup> Although residents may train in other sites within the AMC, only time spent in sites that are owned by the hospital can be counted for purposes of calculating direct medical education payments and only time in the hospital itself may be counted for the indirect adjustment.

---

<sup>8</sup> Billing costs for centralized practice plans account for about 5 percent of net receipts compared with more than 7 percent for departmental plans.

<sup>9</sup> These percentages add to more than 100 because medical schools and training programs typically use more than one hospital.

<sup>10</sup> Medicare policies for financing graduate medical education are discussed in more detail in Chapter 18.



## HOW ARE ACADEMIC CENTERS FARING IN THE MARKETPLACE?

Before policymakers can decide whether they want to intervene to help academic medical centers survive in a more competitive marketplace, it is important to determine just how disadvantaged these centers are now and how disadvantaged they might be in the future.

In theory, academic centers are disadvantaged for two reasons. First, their costs are higher than their community competitors. Second, their approach to medical care may differ substantially from that sought by plans, by having too many specialists and not having systems for managing care. As a result, managed-care plans may be unwilling to contract with AMCs or pay a higher premium for contracting with them. The argument is that, as a result, managed-care plans will steer patients away from academic medical centers. In the end, AMCs will not be able to educate physicians or conduct clinical research, because they will not have sufficient patients or sufficient income to support these core missions.

This section looks at these concerns raised by leaders in academic medicine and examines what is known about academic centers' experiences and their relationships with managed-care plans. There are little data documenting AMCs' experiences relative to other providers. Most of what is known comes from case studies.

### Costs

It is indisputable that academic centers have higher costs than other providers. In 1993, AMC hospitals spent over \$10,084 per adjusted admission, while other hospitals spent under \$7,255 (Reuter et al. 1996).<sup>11</sup> Moreover, the cost gap between AMC hospitals and their community competitors is growing. In 1989, costs per adjusted admission in private AMC hospitals exceeded those of other hospitals in their market by 68.7 percent; by 1994, this figure had grown to 79 percent. The change for public AMC hospitals was even larger, increasing from 42.6 percent in 1989 to 68.3 percent in 1994 (Reuter 1996).

It is not clear, however, what is responsible for this difference in costs. Higher costs may reflect academic centers' relatively sicker patient mix within a given diagnosis-related group, a higher burden of uncompensated care, and activities related to education and research. But these factors account for only some of the observed difference. For example, after case mix adjustment, academic medical centers' costs are about 25 percent higher than their competitors. Moreover, academic centers have asserted (but not measured) that they are producing patient care services of a higher quality than other providers in their community (Sloan 1994). Lacking evidence, plans may assume higher costs reflect inefficiencies in physician practice and hospital operations (Fox and Wasserman 1993).

---

<sup>11</sup> In this context, adjusted admission refers to a measure of hospital activity (admissions plus outpatient services), not to an adjustment for case mix.

## Plans' Willingness to Contract with AMCs

AMCs have two concerns about contracting with managed-care plans: first, whether plans will contract with them at all, and second, whether plans will pay for the additional costs associated with service delivery in academic centers.

So far, concerns that managed-care plans will not contract with AMCs appear unfounded. Plans are contracting with AMCs for individual specialty services through a variety of payment strategies. The most common include discounted fee for service or capitation for packages of services like transplants and cardiovascular services, or comprehensive capitated contracts with a hospital and a faculty practice plan (Fox and Wasserman 1993). Contracting for primary care services appears to be as common as contracting for specialty services. The most recent survey by the American Medical Association found that in 1995, 93 AMCs had contracts with a managed-care plan for provision of primary care services (up from 74 in the previous year) and 96 had contracts to provide specialty services (up from 76 in the previous year) (Barzansky et al. 1996).

AMCs are also contracting with multiple plans within their market. For example, in 1994, University Hospitals in Cleveland had 25 contracts with managed-care plans, including exclusive tertiary contracts with a major commercial insurer (Japsen 1994). Currently, Emory University's health system has more than 140 contracts with managed-care plans (Johns 1996).

Some highly specialized services (for example, burns and transplants) remain the exclusive province of academic centers. The University of California at San Diego (UCSD), for example, has been able to negotiate with a national plan to get stop-losses and favorable rates for some tertiary services based on evidence that it experienced adverse selection. These negotiated rates are about 10 percent higher than they would have been to other providers (Gold and Chu 1994). These services are estimated to account for only a small portion (less than 10 percent) of the total managed-care premium, however (Gold and Chu 1994).

There is some evidence, though, that managed-care plans are steering their enrollees away from AMCs. In a study using hospital discharge data from nine markets with at least one academic medical center, the relative odds of a health maintenance organization (HMO) patient being discharged from an AMC hospital dropped 25 percent (from 0.85 to 0.62) between 1988 and 1991.<sup>12</sup> The drop was more substantial for routine cases (a decline from 1.08 to 0.68) than for complex cases (which only dropped from 0.60 to 0.54). Other large hospitals (both those belonging to the Council of Teaching Hospitals and those with no teaching activity) experienced an increase in the relative odds of HMO patients being discharged from their institutions (Reuter et al. 1996). Because the market has changed so much since 1991, this analysis is now being updated to include data from 1994.

---

<sup>12</sup> That is, in 1991, an HMO patient was only 62 percent as likely as a non-HMO patient to be treated in an academic medical center.

In sum, plans appear to still be determining how they will relate to academic medical centers. Culbertson's interviews with plan managers in Philadelphia, a market with high AMC presence and moderate managed-care penetration, suggests the ambivalence that plans have in contracting with AMCs. They regard academic faculty practices less favorably than other practices in the community because they do not have sufficient numbers of primary care physicians available and are perceived to be inefficient. But they also view inclusion of academic medical centers and their faculties in their provider panels as very important, although it is not clear whether this judgment is based on a marketing advantage or because of quality of care (Culbertson 1996).<sup>13</sup>

Plans do appear to have decided that they will not pay much of a premium for care in AMCs, particularly when reputable alternatives are available (Gold and Chu 1994; Blumenthal and Meyer 1996). In highly competitive markets such as San Diego, the accepted wisdom is that reputation is worth a premium of 3 percent to 10 percent (Blumenthal and Meyer 1996). The fact that plans are willing to pay any premium may reflect marketing strategies to associate them with high-profile institutions (Fox and Wasserman 1993).

Plans have been able to drive the premium down in part because AMCs are not necessarily viewed as indispensable clinical resources. Culbertson (1996) notes, for example, that managed-care plan managers in Atlanta can find specialists in the community who are more amenable than academic practices to their plans' management systems and the compensation they offer. Similarly, in 1993, UCSD accounted for only 7 percent of cardiovascular surgery, 22 percent of tertiary oncology, and 22 percent of tertiary trauma in the San Diego market (Gold and Chu 1994). Ironically, these specialized services are available in the community, in part, because academic medical centers have trained the competition.

## Selection

Another concern of academic leaders is the financial impact of adverse selection: that is, they fear managed-care plans will base their rates on the costs of the average patient but only direct the sickest enrollees to them. Although data are not available on the adequacy of payments to academic centers, a recent study found that managed-care patients seen in these institutions are more likely to be complex cases than those seen in other types of hospitals. In addition, these patients were more likely in 1991 to have complex problems than those seen in 1988 (Reuter et al. 1996).<sup>14</sup> Even so, academic medical centers see a substantial proportion of routine cases among their HMO enrollees.

---

<sup>13</sup> It may be that inclusion is more important in certain markets such as Boston and Philadelphia.

<sup>14</sup> In this study, the researchers used a panel of physicians to separate reasons for hospitalization as either complex or routine. Examples of complex cases include most types of transplants, coronary artery bypass, and extracorporeal membrane oxygenation. Examples of routine cases include joint replacement, routine deliveries, and cholecystectomy (Reuter et al. 1996).

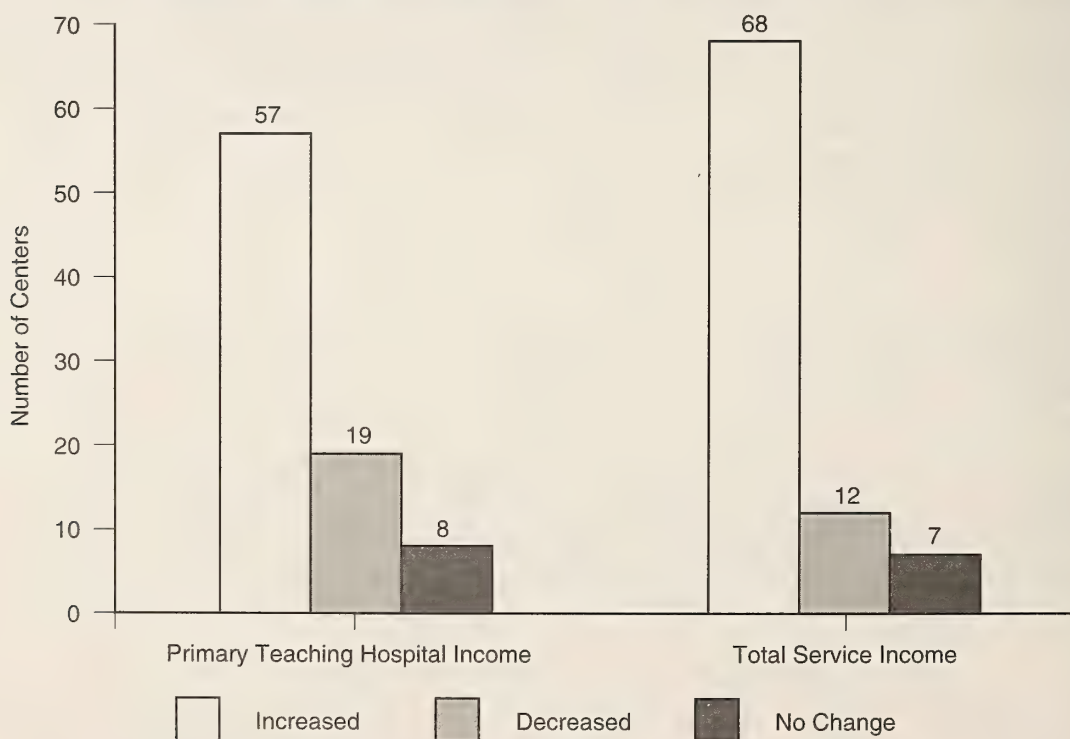


## Financial Performance

Academic medical centers are clearly showing signs of financial stress. In November 1996, for example, Boston Medical Center (the institution created by the merger of Boston City Hospital and Boston University Medical Center) announced massive layoffs to cut \$40 million from the hospital's budget, after having already eliminated 350 positions several months earlier (*American Medical News* 1996). A \$6 million loss attributable to the implementation of TennCare forced one AMC in Tennessee to suspend providing cardiovascular services, lose a cardiothoracic surgeon, and reduce staff by 18 percent (Meyer and Blumenthal 1996). Similarly, George Washington (GW) University Hospital posted a \$15 million loss in 1995, cutting 180 jobs and reducing the number of beds from 350 to 250 (*American Healthline* 1996b).

Nonetheless, there is relatively little evidence that AMC hospitals, as a group, are in worse condition than other hospitals as a result of competition (Gold and Chu 1994).<sup>15</sup> As of 1994, the seven prominent AMCs studied by Blumenthal and Meyer (1996) had not experienced the predicted

**Figure 17-3. Academic Health Centers' Perceptions about Changes in their Financial Positions, 1993-1994 (number)**



SOURCE: Ball and Rubin 1995.

<sup>15</sup> All hospitals, not just academic institutions, have been affected by declining rates of admission and lengths of stay associated with increased managed-care penetration.

negative impact of managed care on either their financial health or their ability to sustain social missions. The Association of Academic Health Centers (AAHC) also found in its 1994 survey that 68 percent of centers expected their total service income to increase in the year ahead, whereas only 12 percent expected income to decline (Figure 17-3).

Hospital margins for teaching hospitals also indicate strong performance. Hadley and Gaskin's (1994) analysis of data from 1984 and 1991 indicated that AMC margins increased during this period of high growth in managed-care penetration while those of other large hospitals decreased somewhat. Moreover, in 1991, AMC hospitals in areas with high managed-care penetration had higher margins than other hospitals, regardless of teaching status.

The Prospective Payment Assessment Commission's most recent analyses of hospital finances for fiscal year 1995 show a mixed picture (Table 17-1). Major teaching hospitals have the lowest total margin of any hospital group. But they have substantially higher Medicare margins. Its analyses also indicate that major teaching hospitals are no more likely than nonteaching hospitals to have negative margins. This may be explained by the higher level of public support for these institutions (ProPAC 1996).

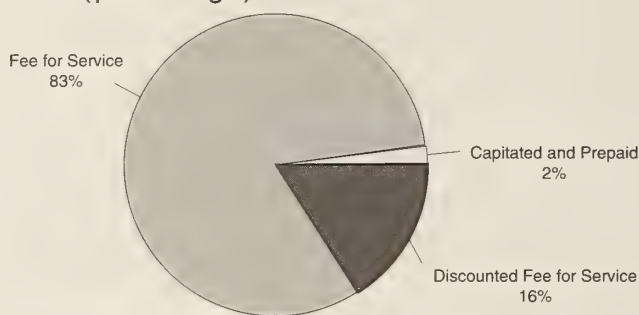
**Table 17-1. Total and Medicare Inpatient Margins by Hospital Type, Fiscal Year 1995 (percentage)**

Hospital Type	Total Margin	Medicare Inpatient Margin
All Hospitals	5.6	7.9
Major Teaching	3.7	18.6
Other Teaching	5.6	7.6
Non Teaching	6.5	3.7
Urban	5.4	8.7
Rural	7.0	3.0

SOURCE: Prospective Payment Assessment Commission 1997.

One explanation for academic institutions' continuing strong performance is that nationally managed care is more a perceived threat than a reality. In the Association of Academic Health Centers' managed-care survey, 90 percent of centers reported that only 20 percent of their patients were enrolled in products that paid AMCs under capitation; 10 percent reported no capitated patients (Ball and Rubin 1995). Approximately 2 percent of faculty practice plan revenue is from capitated or prepaid sources; 16 percent is from discounted fee for service (Figure 17-4). While activity in the Twin Cities and southern California has captured attention, fee for service continues to dominate in many markets where AMCs are located. In Atlanta, for example, where managed-care penetration is only 14 percent, medical school faculty commented to Culbertson (1996) that they were not yet feeling pressures to integrate services and manage care.

**Figure 17-4. Composition of Faculty Practice Plan Professional Services Revenues by Payer, 1995 (percentage)**



SOURCE: Association of American Medical Colleges 1997.

NOTE: Discounted fee for service refers primarily to Medicare, Medicaid, and managed-care plans.

Managed-care enrollment is increasing in markets where AMCs are located, however. Between 1988 and 1995, HMO enrollment rose on average from 14 percent of the population to 29 percent in the markets where most AMCs are located (Reuter et al. 1996). And in the more competitive markets, AMCs are feeling more pressure and being forced to respond. AMCs in markets with high levels of HMO enrollment and growth have lower rates of revenue and expense growth than those in markets with low HMO penetration (Reuter et al. 1996).

### **Educational Activities**

Currently, all medical students and about 59 percent of residents and fellows train in university-based teaching hospitals (Blumenthal and Campbell 1996). Both graduate and undergraduate slots are dependent on patient care revenues; at Duke University, undergraduate medical education alone required an estimated cross-subsidy of at least \$8 million in the 1992-1993 school year (Iglehart 1995a). Educational programs could be threatened if managed-care plans reduce payments to AMCs, will only contract with these institutions for nonteaching services, or refuse to contract with them altogether.

Some AMCs are reducing the number of trainees, although it is unclear whether they are being motivated by local market conditions, fear that Medicare support for training will change dramatically, or the broader public policy debate concerning physician oversupply. As noted in the Commission's *Annual Report to Congress 1996*, Duke plans to trim up to 30 percent of its residency positions within five years, while in Boston, Massachusetts General and Brigham and Women's Hospitals have announced intentions to reduce resident slots by 20 percent by the year 2000 (Kostreski 1995). At least one training program, a psychiatric residency at Timberlawn Mental Health System in Dallas, closed its doors when the institution's managed-care contractors refused to pay for services provided by residents (Mitka 1994). Nationally, however, the number of residents continues to grow, although at slower rates than in the recent past. Moreover, of centers surveyed in 1994, only eight medical schools



had reduced faculty size, seven had decreased fellowship programs, and just one had decreased class size (Ball and Rubin 1995).

While managed-care plans may be hesitant to form relationships with academic medical centers because of cost considerations, they may eventually do so in order to ensure that graduating students are better prepared for practice in managed-care settings. Until recently, there were few opportunities for training in managed-care plans. As of 1990, only 15 percent of mature plans (those four years or older) were directly involved in graduate medical education (Corrigan and Thompson 1991).<sup>16</sup> A 1993 survey of plans by the Group Health Association of America found that over half (55 percent) of managed-care plans had some involvement in graduate medical education. Of these, about 30 percent had formal affiliation agreements to serve as training sites (GHAA 1993).

Training experiences in managed-care plans are increasingly available to medical students. Currently, 16 percent of schools require all students to have clerkships or other experiences in a group or staff model HMO; in about half of schools, some students spend time in a managed-care plan. That represents an increase from 15 years ago, when only about 20 percent of schools had arrangements with managed-care plans to allow clinical experiences in a managed-care setting. Educational involvement by independent practice association (IPA) model plans and for-profit plans is still infrequent, however, despite the fact that these are among the fastest-growing managed-care arrangements (Veloski et al. 1996).

The Pew Charitable Trusts has funded a major initiative (\$8.3 million over a three-year period) to help prepare future physicians for practice in the managed-care environment. It will support up to five partnerships between AMCs and managed-care plans, collaborative efforts among the partnerships, and evaluation. Three partnerships have already been funded at Tufts (Tufts Health Plans), Harvard (Harvard Pilgrim Health Care), and Case Western Reserve (Henry Ford Health System) (Grantwatch 1996).

## **Research Activities**

Threats to the level of research activity in AMCs stem from two sources: potential cuts in funding from the federal government—primarily the National Institutes of Health (NIH)—and diminishing revenues from patient care to support both clinical and basic research. Close to 90 percent of support for life science research in academic centers is from government and other nonprofit sources (including faculty practice plans); industry supported 11.7 percent of research funding in 1994, primarily for clinical research (Blumenthal and Campbell 1996). Academic centers also provide internal subsidies for clinical research in the form of items such as supplies, operating room time, and nursing effort. One study of five AMCs suggested that these contributions amounted to about 20 percent of the total costs of research (Blumenthal and Campbell 1996).

---

<sup>16</sup> Managed-care plans with longstanding affiliations with training programs include the George Washington University Health Plan, the Harvard Community Health Plan (now Harvard Pilgrim), Group Health of Puget Sound, and Kaiser Permanente.

There is some anecdotal evidence that increased competition in the market for health services is squeezing the ability of academic medical centers to conduct basic and clinical research. These anecdotes include loss of seed money, flight of researchers from schools in areas with high managed-care penetration, and difficulty finding research subjects (*Managed Care and Medical Research* 1996; *American Healthline* 1996d). In addition, a new study shows that there is a relationship between the ability of medical schools to compete for external research funding and the level of competition in the health services market. Since 1990, the rate of growth in NIH awards has been lower for schools in markets with high managed-care penetration (Moy et al. 1996).

### **Uncompensated Care**

The ability of academic medical centers to provide uncompensated care could be threatened if cross subsidies from other payers are no longer available. Currently, teaching hospitals associated with AMCs have a disproportionate commitment to this activity. Hospitals belonging to the Council of Teaching Hospitals (the nation's largest teaching hospitals including hospitals that are part of AMCs) account for just 6 percent of all U.S. hospitals but 35 percent of all uncompensated care (AAMC 1996a). Moreover, urban AMCs are more likely to take care of patients with low-incomes and those with Medicaid coverage; Medicaid beneficiaries are twice as likely to be hospitalized in an integrated AMC as opposed to a nonteaching hospital relative to those with Blue Cross or commercial insurance.<sup>17</sup> People with incomes below \$15,000 are 10 times more likely to be hospitalized in an integrated AMC instead of a nonteaching hospital relative to those with incomes of \$45,000 and above (Moy et al. undated).

There are distinctions based on ownership status, however. Public major teaching hospitals have higher overall revenue losses (defined as the difference between charges and payments) from managed care than other types of hospitals (8 percent of total costs). Losses of nonpublic major teaching hospitals are similar to those of nonteaching hospitals (4.7 percent and 4.5 percent respectively) (ProPAC 1996).

### **RESPONDING TO MARKET CHANGE**

Despite the uncertainty about the future that academic centers will face, most of these centers are actively working to position themselves for survival in a more competitive marketplace. A 1994 survey of academic health centers found substantial activity in response to external changes in the market for health services. In the 12 months before the survey, 80 percent of centers had taken actions to expand clinical programs, establish linkages, or downsize the teaching hospital (Ball and Rubin 1995). This section describes the range of strategies now being pursued by academic medical centers including reducing operating expenses; undergoing hospital conversions and mergers; developing integrated systems; and creating new products and markets. Obstacles to change are also considered.

---

<sup>17</sup> In this study, integrated AMCs were defined as those in which the hospital has common ownership with a medical school or in which most chiefs of clinical services are department chairs in the medical school.

Of the strategies described below, it is not clear which of these strategies will be most effective in ensuring viability. This uncertainty stems from several sources. First, there are many differences across institutions in governance, ownership, access to capital, and historical relationships. Second, different strategies are likely to be more appropriate in mature markets and in those where competitive forces are just beginning to be felt. Moreover, given the unpredictability of how market forces will play out, it is unclear how these strategies will work as the market continues to change. Third, market forces may ultimately affect demand for education, research, and patient care produced by AMCs.

### **Reducing Operating Expenses**

A first step for many hospitals that are part of academic centers has been to lower the costs of providing clinical services by reducing administrative overhead, closing beds, securing better prices from vendors, and reengineering processes of care. The seven major centers studied by Blumenthal and Meyer (1996) were all seeking to reduce hospital operating expenses by an average of 20 percent over three to five years. In the AAHC's survey of 88 centers, 33 had decreased the number of beds, 44 had decreased nursing staff, and 48 were decreasing other staff (Ball and Rubin 1995).

### **Hospital Conversions**

A few institutions are cutting costs by changing their relationships with their primary teaching hospital. Tulane University, for example, sold its hospital for \$132 million to Columbia/HCA. The university retains a 20 percent stake in the hospital which will be used to support teaching and research programs. In addition to committing \$75 million to support the hospital's Centers of Excellence and another \$75 million for capital improvements, Columbia will also financially assist the medical school and the school of public health (Pickett 1996).

In the fall of 1996, George Washington University entered into an agreement with OrNda, a for-profit hospital chain, to purchase an 80 percent interest in the university hospital for \$80 million. OrNda owns 50 hospitals nationwide; GW is the first academic medical center that it has acquired (*American Healthline* 1996b).

Also in late 1996, University of Cincinnati trustees approved a plan to privatize the hospital by leasing its assets to a private nonprofit organization. Privatization will make it easier for the hospital to cut costs by exempting the hospital from several state regulations. It will also remove barriers to cooperating with other local hospitals for cost-cutting purposes by reducing duplicate services (*American Healthline* 1996e).

Legislators in several states are trying to slow or halt the acquisition of public AMC hospitals by for-profit chains. In 1996, 11 states enacted legislation strengthening state oversight of such transactions. In South Carolina, a lawsuit has been filed to block the Medical University of South Carolina from leasing its hospital and clinics to Columbia/HCA. In California, the attorney general has intervened in discussions between for-profit chains and teaching hospitals at the University of California's Irvine and San Diego campuses (Schmidt 1996).



## Mergers

Perhaps the most high profile strategy being undertaken by AMCs are mergers of hospitals and medical schools, particularly in relatively competitive markets. These consolidations serve the purpose of securing economies of scale, ensuring a patient base, and sending a message to other actors in their markets (Epstein 1995). Recent mergers include:

- University of California at San Francisco (UCSF) and Stanford University Hospitals, effective July 1, 1997. Integration of services is being considered for some services (pediatrics and oncology). The 40-mile distance between the two campuses will force duplication in some areas, however (for example, routine obstetrics) (Kerr 1996). In addition, the medical staffs of UCSF and its cross-town competitor, the California Pacific Medical Center, have merged to form the 1,250 physician Brown and Toland Medical Group. This merger became effective January 1, 1997.
- Boston has seen three high profile mergers: Brigham and Women's and Massachusetts General Hospitals into Partners; Boston University Hospital and Boston City Hospital into the Boston Medical Center; and Beth Israel and the Deaconess Hospitals under the name, CareGroup.
- Mergers in New York City include New York Hospital and Presbyterian Hospital of the City of New York (a system that will include 20 hospitals with combined annual revenue of \$2.5 billion); Columbia and Cornell, which are creating a 2,800 physician alliance among faculty physicians to negotiate managed-care contracts, although the schools will remain separate (Mitka 1996a; Mitka 1996b).

Mergers may also come after other strategies in reaction to market changes have been tried. Consider the experience of the University of Minnesota. In 1993, after posting operating losses for three consecutive years, the university announced plans to form its own health system and take a number of drastic steps to improve the efficiency of its hospital. These included cutting \$45 million from its \$300 million operating budget, reducing the number of employees from 4,100 to 3,400, trimming employee benefits, refinancing debt, restructuring malpractice coverage, and changing the use of supplies (Japsen 1994; Page 1994). These measures apparently were not sufficient to keep the university hospital afloat, however. In August 1996, the university announced a merger between the university hospital and the private Fairview Health System. Provost William Brody noted that had the university not taken this approach, it would have faced "massive downsizing" (*American Healthline* 1995a and 1996a).

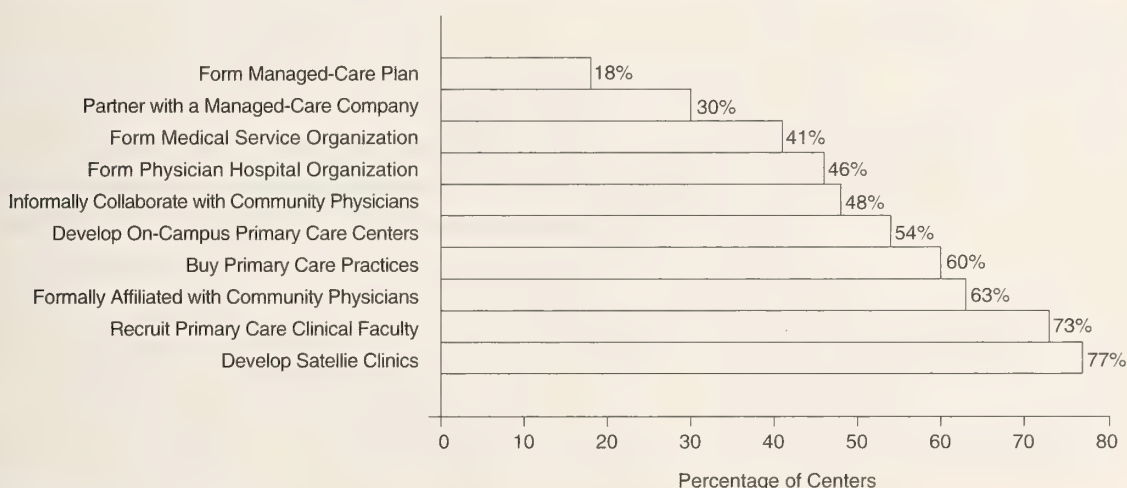
## Development of Integrated Systems

Academic centers are also looking into the community for partners. Virtually all of them (90 percent in the AAHC's survey) are linking with other hospitals and community-based physicians (Ball and Rubin 1995). In the past year alone, 57 medical schools acquired primary care physician practices, and 70 started primary care clinics in the community (Barzansky et al. 1996).

These efforts have three motivations. First, AMCs need a larger primary care base to support their specialized faculty and facilities. Second, in order to secure managed-care contracts, AMCs need to be able to deliver a continuum of care, including primary care, acute and subacute institutional care, and professional services from a range of providers. Third, a primary care base is needed to support educational activities for the growing number of medical students and residents interested in generalist careers.

Academic medical centers pursue a number of different strategies to build a primary care capacity. These range from informally collaborating with community physicians to forming their own managed-care plan (Figure 17-5).

**Figure 17-5. How Academic Medical Centers Build Primary Care Capacity (percentage)**



SOURCE: Kostreski 1996.

These integrated systems can take a variety of forms (Figure 17-5). In less mature markets, where managed care has not taken hold and AMCs have more room to maneuver, a number are competing head-to-head with managed-care plans (Culbertson 1996). In the Association of Academic Health Center's 1992 survey, 37 of 86 responding institutions reported owning a managed-care plan. In a followup survey conducted in 1994, half the respondents had either expanded or started a plan in past year (Ball and Rubin 1995).

Several AMCs have developed products as joint ventures with managed-care plans for the express purpose of competing for Medicaid beneficiaries. The University of Oklahoma has partnered with a private management company, Schaller Anderson, to manage the center's professional practice plan and market it to the Medicaid population (*American Healthline* 1995b). At the University of Miami, the school of medicine and Jackson Memorial Hospital have affiliated with Physician Corporation of America, a for-profit plan, to serve Medicaid beneficiaries. Egelston, the private children's hospital affiliated with Emory University, has also launched its own managed-care product for this population.

In more mature markets, where AMCs want to preserve their ability to contract with major plans, they are forming integrated systems that can offer a comprehensive package of services. In addition to the University of Pennsylvania, which has an aggressive strategy of purchasing primary care physician practices, other AMCs taking this approach include Boston's Partners, the University of Cincinnati, the University of Michigan, and the University of Maryland. Partners' network includes 600 primary care physician practices (only some of which are owned by Partners) plus community hospitals, home health agencies, a psychiatric facility, and a rehabilitation hospital.

The role that community-based primary care physicians will play in these institutions is still evolving. For the community-based physician, alliances with AMCs provide prestige, and access to both research and capital. There are uncertainties, however, about how these community-based physicians will be integrated into the academic enterprise.

### **Developing New Products and Markets**

AMCs are also seeking to compete by trading on their name recognition. In some cases, this means developing a market niche such as providing complex technical procedures, or serving the baby boom generation with special programs such as sports medicine and women's health services (Epstein 1995). Johns Hopkins is providing luxury hotel-like accommodations targeted to corporate executives and the international trade. New geographic locations are also being tested, with the Mayo Clinic expanding into Arizona and Florida, and the Dana-Farber Cancer Institute forming clinical relationships with hospitals in Vermont, Maine, and New Hampshire, as well as communities in Massachusetts outside the Boston area.

### **Other Strategies**

Other strategies are also being pursued. These include increasing sales of nonclinical services such as research, intellectual property, and continuing medical education, as well as reducing the cost of providing these services (Blumenthal and Meyer 1996). For example, John Hopkins has formed a new company to commercialize drug research of Hopkins faculty. The university retains a 45 percent stake in the company, a percentage of licensing payments, and a share of royalties for future licenses (*American Healthline* 1996c).

### **Obstacles to Change**

Many obstacles will frustrate AMC efforts to respond to market changes. In fact, when the Association of Academic Health Centers surveyed its members and asked an open-ended question about the greatest obstacle to change, there were 99 separate responses. About two-thirds perceived academic relations and university culture to be the biggest hurdles, followed by faculty attitudes, departmental structure and turf issues, and university governance (Ball and Rubin 1995). Given that the cost of creating a primary care physician network is estimated at \$50 million to \$100 million, access to capital is another key barrier to change (Iglehart 1995a).



Fox and Wasserman (1993) consider the goals of managed care and academic medical centers to be “structurally incompatible.” Among the differences they note are those affecting rewards (publishing and tenure versus clinical productivity); model for behavior (autonomous actors versus collaborative relationships); and resource use (innovation and experimentation without regard to cost versus prudent management). Goals may be changing at many AMCs, however, to reflect changing market conditions.

One key impediment is the traditional departmental structure of academic medical centers.<sup>18</sup> Decisionmaking within the AMC is fragmented, involving many players of differing views (deans and department chairs versus hospital administrators, for example). Competing for managed-care contracts, however, requires quick and decisive action. Moreover, accepting capitation requires that decisions be made about the system of care—that is, who will do what, and how revenues will be allocated across institutions within the AMC as well as across clinical departments.

Also creating friction are changes in so-called town and gown relationships that occur as AMCs broaden their networks to include community physicians, particularly those in primary care. Goldman (1995) notes the difficulty faculty physicians have in working with (or competing against) “the same so-called LMDs—local medical doctors—whom they previously scorned.”

## RESEARCH EFFORTS

There are many gaps in understanding about the experiences of academic medical centers and how they will fare as managed-care penetration rates increase and pressures to hold down costs mount. A number of research efforts, primarily funded by foundations, are under way that will help fill some, but not all of these gaps.

The Commonwealth Fund has launched a four-year, \$3.5 million program concerning academic health centers and market change. This effort has three purposes:

- to collect and analyze data on effects of environmental pressures on centers’ ability to perform their social missions,
- to develop and disseminate innovative solutions, and
- to propose public policies to preserve and enhance AMC social missions.

Anticipated projects include case studies, surveys of center leaders, surveys of faculty and trainees, literature reviews, and reports. A national task force chaired by Samuel Thier, president of

---

<sup>18</sup> Although about 80 percent of centers responding to the AAHC’s survey reported having a single coordinated faculty practice plan, 60 percent of these were not independent of departmental structure (Ball and Rubin 1995).

Massachusetts General Hospital, is directing this effort, and collaboration is planned with both the Association of Academic Health Centers and the Association of American Medical Colleges.

The Commonwealth Fund is also funding additional work by researchers at Georgetown University's Institute for Health Care Research and Policy to look at the experience of academic medical centers in the era of managed care. Issues on their research agenda include changes in AMC market areas and the types of hospitals and scope of contracts being used by managed-care plans (and Medicare risk-contracting plans, in particular). A survey of contracting practices has recently been completed; analyses from this survey are expected to be available later this year.

The AAMC has created the Center for the Assessment and Management of Change in Academic Medicine to analyze the impact of market change on AMCs and assist them in adapting. One of the center's key activities has been development of a network of 15 AMCs that can provide information on environmental changes and innovative models of response. In addition, the center is reexamining the AAMC's current databases in an effort to make these more compatible, and more useful for analysis of market trends.

## CONCLUSIONS

The limited evidence available does not suggest that academic medical centers are currently in deep distress. If these centers have excess capacity (both in terms of patient care and their ability to produce physicians), then market pressures may provide the needed impetus for them to improve their efficiency and shift the nature of their products.

There are several ways to interpret the data on academic centers' performance in the marketplace, however. First, AMCs may be performing well now, but a crisis may still loom a year or two in the future. Second, national data may obscure differences at the market level. Third, the right data may not be available even at the market level. For example, data on financial performance may not adequately capture the extent of adverse risk selection. In order to know what signals policymakers should be looking for, the Congress will need to consider which missions are most threatened by market competition, which should be supported from public sources, and the appropriate level of such support. To assist the Congress, the Commission will continue to follow developments in this area.

Part of the difficulty in making these judgments stems from uncertainty about where the health care market is headed. It is unclear whether there is a limit to the ability of managed-care plans to squeeze down on these institutions and what would be lost if there are fewer academic medical centers in the future. Moreover, the experiences of mature markets may not be particularly instructive in answering these questions. First, market evolution in the Twin Cities and southern California differ substantially. Second, it is not clear that the strategies adopted by payers, providers, and AMCs in those markets are those that should be adopted in other areas of the country.

## REFERENCES

- American Healthline*, "Hospitals and Health Systems—University of Minnesota Regents Approve Merger," August 1, 1996a.
- American Healthline*, "Inside the Industry: George Washington University Signs with OrNda," October 28, 1996b.
- American Healthline*, "Inside the Industry: Johns Hopkins Forms Venture to Market Medical Research," October 17, 1996c.
- American Healthline*, "Inside the Industry: Boston Doctors Leaving in Search of Funds," July 17, 1996d.
- American Healthline*, "Hospitals and Health Systems—U. Cincinnati Hospital Board Approves Privatization," October 10, 1996e.
- American Healthline*, "Statelines—Minnesota: University to Enter New Health System," November 22, 1995a.
- American Healthline*, "Statelines—Oklahoma: Medicaid Changes Prompt University to Explore Options," March 28, 1995b.
- American Medical Association, letter to the Physician Payment Review Commission, February 25, 1997.
- American Medical News*, "Boston Medical Center Plans Additional Massive Layoffs to Cut \$40 Million," November 4, 1996.
- American Osteopathic Association and American Association of Colleges of Osteopathic Medicine, letter to the Physician Payment Review Commission, February 26, 1997.
- Association of American Medical Colleges, *AAMC Data Book: Statistical Information Related to Medical Education* (Washington, DC: January 1996a).
- Association of American Medical Colleges, *The Financing of Medical Schools: A Report of the AAMC Task Force on Medical School Financing* (Washington, DC: November 1996b).
- Ball, John, and Elaine Rubin, *Academic Health Centers: Structures and Strategies for Coping with the Managed Care Environment* (Washington, DC: Association of Academic Health Centers, 1995).
- Barzansky, Barbara, Harry S. Jonas, Sylvia I. Etzel, "Educational Programs in U.S. Medical Schools, 1995-1996," *Journal of the American Medical Association* 276(9): 714-719, September 4, 1996.
- Blumenthal, David, and Eric G. Campbell, *Understanding the Social Missions of Academic Health Centers* (New York: Commonwealth Fund Task Force on Academic Health Centers, November 1996).



- Blumenthal, David, and Gregg S. Meyer, "Academic Health Centers in a Changing Environment," *Health Affairs* 15(2): 200-215, Summer 1996.
- Corrigan, Janet M., and Laurie M. Thompson, "Involvement of Health Maintenance Organizations in Graduate Medical Education," *Academic Medicine* 66(11): 656-661, November 1991.
- Culbertson, Richard A., "How Successfully can Academic Faculty Practices Compete in Developing Managed Care Markets?" *Academic Medicine* 71(8): 858-870, August 1996.
- Dickler, Robert M., and Linda E. Fishman, "Preserving the Mission," *Health Systems REVIEW* 22-25, May-June 1996.
- Epstein, Arnold M., "U.S. Teaching Hospitals in the Evolving Health Care System," *Journal of the American Medical Association* 273(15): 1203-1207, April 19, 1995.
- Fox, Peter D., and Jeff Wasserman, "Academic Medical Centers and Managed Care: Uneasy Partners," *Health Affairs* 12(1): 85-93, Spring 1993.
- Hadley, Jack, and Darrell J. Gaskin, *HMO Penetration and Academic Health Center Hospitals' Mission 1984-1991/92*, paper presented at the annual meeting of the Association of Academic Health Centers, October 1, 1994.
- Ginzberg, Eli, Miriam Ostow, and Anna B. Dutka, *The Economics of Medical Education* (New York: Josiah Macy, Jr. Foundation, March 1993).
- Gold, Marsha, and Karyen Chu, *Financing of Academic Medical Centers and Graduate Medical Education under Competitive Systems with Managed Care*, report to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, December 23, 1994.
- Goldman, Lee, "The Academic Health Care System: Preserving the Missions as the Paradigm Shifts," *Journal of the American Medical Association* 273(19): 1549-1552, May 17, 1995.
- "Grantwatch," *Health Affairs* 15(4): 189-190, Winter 1996.
- Group Health Association of America, *Recruitment Experience of Health Maintenance Organizations for Primary Care Physicians* (Washington, DC: May 1993).
- Hadley, Jack, and Darrell J. Gaskin, *HMO Penetration and Academic Health Center Hospitals' Mission: 1984-1991/92*, paper presented at the annual meeting of the Association of Academic Health Centers, October 1, 1994.
- Iglehart, John K., "Conference Summary: Duke University Conference on the Private Sector," *Health Affairs* 14(1): 305-311, Spring 1995a.
- Iglehart, John K., "Rapid Changes for Academic Medical Centers: Second of Two Parts," *New England Journal of Medicine* 332(6): 407-411, February 9, 1995b.
- Japsen, Bruce, "Teaching Hospitals Face Hard Lessons," *Modern Healthcare*, February 7, 1994, p. 36-40.

- Johns, Michael M.E., Emory University Health System, comments made before the Commonwealth Fund Task Force on Academic Health Centers, November 21, 1996.
- Jones, Robert F., *American Medical Education: Institutions, Programs, and Issues* (Washington, DC: Association of American Medical Colleges, November 1992).
- Kerr, William, University of California at San Francisco, comments made before the Commonwealth Fund Task Force on Academic Health Centers, November 21, 1996.
- Krakower, Jack Y., Janice L. Ganem, and Paul Jolly, "Review of U.S. Medical School Finances, 1994-1995," *Journal of the American Medical Association* 276(9): 720-724, September 4, 1996.
- Kostreski, Farah, "Academic Medical Centers Buying Practices," *Family Practice News*, May 15, 1996, p. 53.
- Kostreski, Farah, "Market Forces Drive Cuts In Residency Slots," *Family Practice News*, December 1, 1995, p. 37.
- Managed Care and Medical Research: An Overview*, memo to ICD directors and senior OD staff, National Institutes of Health, from Associate Director for Science Policy, September 13, 1996.
- Meyer, Gregg, and David Blumenthal, "TennCare and Academic Medical Centers: The Lessons from Tennessee," *Journal of the American Medical Association* 276(9): 672-676, September 4, 1996.
- Mitka, Mike, "Managed Care Blamed for End of Residency Program," *American Medical News*, August 22-29, 1994, p. 6.
- Mitka, Mike, "Medical Schools Merging in New York: Impact on Residency Programs Uncertain," *American Medical News*, July 29, 1996a, p. 3.
- Mitka, Mike, "N.Y. Hospital Merger Mania," *American Medical News*, August 12, 1996b, p. 3.
- Moy, Ernest, Anthony J. Mazzaschi, Rebecca J. Levin, et al., "Growth in NIH Research Awards to U.S. Medical Schools from 1986 to 1995 in Different Managed Care Markets," unpublished paper, 1996.
- Moy, Ernest, Ernest Valente, Jr., Rebecca J. Levin, and Paul Griner, "Academic Medical Centers and the Care of Underserved Populations," unpublished paper, undated.
- Page, Leigh, "Playing Catch-Up: The University of Minnesota Hospital is Reorganizing Itself to Become a Major Player in a Highly Competitive Local Market," *American Medical News*, August 1, 1994, p. 3, 7-8.
- Pickett, Stephen, "An Academic Marriage," *Health Systems REVIEW*, May-June 1996, p. 26.
- Prospective Payment Assessment Commission, *Medicare and the American Health Care System* (Washington, DC: June 1996).

Prospective Payment Assessment Commission, unpublished table, 1997.

Reuter, James, *The Financing of Academic Health Centers* (Washington, DC: Institute for Health Care Research and Policy, Georgetown University, April 1996).

Reuter, James, Darrell J. Gaskin, Jack Hadley, and David Propp, *HMOs' Use of Academic Health Centers IWP #96-103* (Washington, DC: Institute for Health Care Research and Policy, Georgetown University, March 1996).

Schmidt, Peter, "States Trying to Slow Corporate Acquisition of Academic Hospitals," *Chronicle of Higher Education*, December 20, 1996, p. A-25.

Sloan, Frank, "Responses," in *The Academic Health Center and Health Care Reform: Proceedings of the Duke Private Sector Conference 1994*, Ralph Snyderman, Mark C. Rogers, and Vicki Y. Saito, eds. (New York: Raven Press, 1994).

Veloski, Jon, Barbara Barzansky, David B. Nash, et al., "Medical Student Education in Managed Care Settings: Beyond HMOs," *Journal of the American Medical Association* 276(9): 667-671, September 4, 1996.



# Financing Graduate Medical Education and Teaching Hospitals from a Trust Fund

Under the Omnibus Budget Reconciliation Act of 1990 (OBRA90), the Congress expanded the Physician Payment Review Commission's mandate, directing it to review and consider Medicare payments for graduate medical education (GME). For several years, the Commission's work in this area reflected policymakers' interest in using Medicare funds to leverage changes in the supply and specialty mix of physicians. It embarked on a variety of activities, including reviewing data on physician supply and distribution; studying related public and private-sector efforts; examining the impact of previous policy initiatives; and hearing from physicians, policy experts, and medical educators. The Commission concluded that there was a need to slow growth in the aggregate supply of physicians and reach a more appropriate balance across specialties. In its 1993 and 1994 annual reports, the Commission recommended a new system for financing graduate medical education, including extensive changes in Medicare policy, that would limit future growth in resident supply, rationalize the allocation of residency positions, and make entities sponsoring training programs more accountable to the nation's health care needs (PPRC 1993; PPRC 1994).

In 1997, the Congress continues to be interested in reforms in Medicare payments for GME. Work force issues are of less interest, however, given the widely held view that changes in the market for health services will correct problems of physician oversupply and imbalance in specialty mix. Instead, decisionmakers are now focusing on how to change Medicare policies to make them more rational, equitable, and less of an

*This chapter includes:*

- *Rationales for Medicare support of teaching hospitals and graduate medical education*
- *Rationales for other forms of public support of these activities*
- *A review of problems with current Medicare policy*
- *A discussion of the implications of creating a trust fund for these activities*

impediment to change as educators seek to adapt graduate medical education to changes in the nation's health and its health system.

One approach to reform is to place Medicare revenues in a trust fund from which payments to hospitals, training programs, or medical schools could be made based on principles other than hospital costs and admissions.<sup>1</sup> That was the approach taken in various forms in the 104th Congress under Medicare restructuring legislation enacted by both the House and Senate and a bill introduced by Senator Daniel Patrick Moynihan. Since these proposals did not become law, they form the starting point for debate in the 105th Congress.<sup>2</sup>

This chapter provides a framework for considering changes in Medicare financing of GME. It begins by sketching out the potential rationales for Medicare support of teaching hospitals and graduate medical education, and the rationale for financing these activities from other sources (either through general revenues or other payers). Assuming that Medicare will continue to provide support for these activities, the chapter then describes five problems with current policy that require attention. The advantages and disadvantages of creating a trust fund to support these activities as opposed to current methods are then considered. The chapter concludes by outlining future work the Commission will undertake in this area.

The Commission's previous work on GME financing extended only to analysis of Medicare payments for the direct costs of graduate medical education (residents' salaries and benefits, supervision, and overhead). That is because the indirect medical education (IME) adjustment was not designed to support teaching per se. Rather, it was meant to compensate teaching institutions for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. These issues fall within the purview and expertise of the Prospective Payment Assessment Commission (ProPAC).

## **RATIONALES FOR MEDICARE SUPPORT FOR TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION**

In considering how Medicare dollars might be reallocated among teaching hospitals, training programs, and medical schools, one must first begin by determining the purpose of such support.<sup>3</sup> All other

---

<sup>1</sup> Teaching hospitals are defined as those with at least one resident in an accredited training program. Training programs are the accredited entities sponsoring graduate medical education; most of the nation's 7,600 training programs are based in hospitals. Medical schools provide educational experience for medical students; they do not provide graduate medical education although medical school faculty may be training program directors and faculty.

<sup>2</sup> Senator Moynihan introduced a substantially similar bill, S. 71, the Medical Trust Fund Act of 1997, in January 1997.

<sup>3</sup> Medicare support is now available to any hospital with at least one resident in an accredited program. There are no additional policies targeted at the much smaller group of teaching hospitals that are part of academic medical centers. Medicare does not provide direct support to medical schools.

decisions (for example, who can get the money and how much they are eligible to receive) should flow from a common understanding about these purposes.

This section discusses three different reasons why it may be appropriate for the Medicare program to provide special support for teaching hospitals. Special support may be needed to (1) ensure beneficiary access to teaching hospitals, (2) ensure the viability of teaching hospitals, or (3) support the training of physicians to meet Medicare beneficiaries' needs. A case can also be made that there is no compelling rationale for continuing Medicare support. The discussion is intended to draw out how basing policy on any particular rationale might affect decisions about allocations.

### **Maintaining Beneficiary Access to Services in Teaching Institutions**

The report accompanying the 1965 Social Security Amendments notes that the original intent of Medicare's support of the special costs incurred by teaching institutions was to ensure that beneficiaries could receive care in the best hospitals, those where training also occurred. As noted in the Ways and Means Committee report:

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program (Committee on Ways and Means 1965).

Medical research costs, by contrast, were not to be paid for by Medicare for two reasons. First, these were "over and above the costs closely related to normal patient care." Second, "ample" funding from other sources was available.

This rationale of tying Medicare dollars to activities benefiting Medicare patients remains evident in current Medicare policy, despite the shift from payment based on a pass-through of reasonable costs for direct medical education payments and application to per case payments of an indirect medical education adjustment.<sup>4</sup> Under both payment formulas, Medicare only pays hospitals that admit Medicare beneficiaries, and determines its share based on the level of Medicare activity (specifically, the number of bed days) in each institution.

---

<sup>4</sup> In Medicare's early years, graduate medical education was funded like other hospital services on a retrospective, reasonable cost basis. With the adoption of prospective, per case payment in the early 1980s, direct medical education payments and the indirect medical education adjustment were adopted to ensure equitable payment for teaching hospitals.



Does beneficiary access to teaching hospitals remain a compelling policy concern? Despite the many changes in the health care system, public perceptions still often tend to equate teaching status with high-quality care. For example, only teaching hospitals can be considered for inclusion in *U.S. News and World Report's* annual rankings of the nation's best hospitals.<sup>5</sup> But many complex services, such as open-heart surgery and organ transplants, that were previously available exclusively in academic settings, are now provided in nonteaching hospitals where costs are typically lower and outcomes are often comparable.

One implication of the expansion of Medicare managed care will be the transfer of decisions regarding whether to use a teaching hospital from patients and their physicians to managed-care plans. Although there are no good data on the extent to which Medicare risk plans use teaching hospitals, the assumption is that most managed-care plans will use teaching hospitals only if comparable services are not available elsewhere or if including these providers in their networks makes the plan more marketable. It may be difficult to argue, therefore, that Medicare support is critical to ensuring beneficiaries' access to teaching institutions when there are no such assurances of access for those beneficiaries who are enrolled in managed care.

### **Ensuring the Viability of Teaching Hospitals**

A second rationale for Medicare support of teaching hospitals is that the nation's academic medical centers are unique resources that have laid the groundwork for important medical advances, ensured the quality of medical education and the competence of practicing physicians, and continue to provide a wealth of specialized health services (Commonwealth 1985; AAMC 1992; Neville 1995). Beginning with recognition of the costs of clinical education as reasonable costs, Medicare policies have been designed to level the playing field so that teaching hospitals are not disadvantaged in a competitive environment by a payment system that does not account for all the relevant factors that explain their higher costs (Anderson undated).

This rationale may have greater relevance now as academic centers attempt to respond to competitive pressures arising from growth in managed-care penetration.<sup>6</sup> For example, recently, academic institutions have argued that new policies are needed so that managed-care plans with Medicare risk contracts will be willing to contract with them. In particular, academic medicine is arguing that medical education payments should be excluded from calculation of capitation payments and paid directly to a teaching hospital when a Medicare managed-care enrollee incurs a bed day (AAMC 1995).<sup>7</sup>

---

<sup>5</sup> According to the magazine, these rankings, while unscientific, are intended to help consumers help identify the best hospitals for diagnosing or treating complex or serious illnesses.

<sup>6</sup> Academic medical centers' responses to the changing health care marketplace are considered in Chapter 17.

<sup>7</sup> This issue is discussed in detail in Chapter 3.

Given the increasingly cost-conscious health environment and declining use of hospital services, at issue is how much federal support for teaching hospitals is warranted and whether recognition of these costs by Medicare in the form of IME and direct medical education payments is an appropriate vehicle. Those arguing for cutbacks in federal support point out that since the prospective payment system was implemented, teaching hospitals' Medicare inpatient margins (defined as the difference between Medicare revenues and expenses) have exceeded those of other hospitals. In fiscal year 1995, major teaching hospitals (those with at least 0.25 residents per bed) had the highest Medicare inpatient margin at 18.6 percent. Margins for other teaching hospitals were 7.6 percent and those of nonteaching hospitals were 3.7 percent (ProPAC 1997).

Teaching hospitals are taking steps to respond to the changing health care environment (see Chapter 17). Academic centers are developing new sources of revenue; creating new organizations to negotiate managed-care contracts; building networks of providers through mergers, acquisitions, and contract arrangements; and differentiating their products. Steps are also being taken to reduce costs by freezing salaries, not filling vacant faculty positions, and downsizing hospital staffs (Iglehart 1995).

Total margins, as opposed to Medicare margins, however, suggest the pressures now being faced by teaching institutions. Major teaching hospitals have the lowest total margins at 3.7 percent (compared with 6.5 percent for nonteaching hospitals), reflecting a combination of heavy uncompensated care burdens, inefficiencies, and payments from many payers that do not recognize the full incremental costs of education (ProPAC 1997). Medicare's special payments to teaching institutions therefore are viewed as a thin buffer from powerful market forces that do not value missions beyond patient care.

### **Supporting the Training of Physicians to Meet Beneficiary Needs**

A third rationale for Medicare funding of GME is that the program should support training of physicians sufficient to ensure that Medicare beneficiaries have access to appropriate medical care. The argument is based on the premise that since the community (the term used in the original legislation) does not support physician training, public financing is appropriate to ensure that Medicare beneficiaries have access to physicians. To the extent that these costs are no longer subsidized, potential candidates might decide to enter other professions (Gurnick et al. 1991). Public support of GME thus ensures that there is a sufficient supply and mix of physicians to meet beneficiary health care needs.

This rationale is consistent with concerns at the time of Medicare's enactment about an impending physician shortage. Noting that physician supply was not keeping pace with population growth and increased demand for services, several influential reports called for direct federal assistance to increase regional physician-to-population ratios (Reinhardt 1990). The Health Professions Educational Assistance Act of 1963 (P.L. 89-290) offered construction grants to health professions schools that agreed to increase enrollment, allocating specific dollar amounts per student (capitation grants) to the schools, and providing loans to students. Subsequent amendments to this legislation, including the 1968 Health Manpower Act (P.L. 90-490), increased capitation grants and expanded loan and



scholarship programs (Lee et al. 1976). Residency programs also expanded rapidly during this period. Between 1970 and 1989, the number of training programs increased from 4,665 to 6,421; the number of positions offered almost doubled, growing from 42,614 to 84,893 (Swanson 1992).

Today, however, concerns focus on the effects of oversupply, rather than shortage, raising the question of whether such support for medical education is still warranted. Reinhardt (1994) argues that continued subsidies could be justified under two conditions: (1) a dearth of applicants to medical schools or residency programs, or (2) expectations that physician incomes would fall so low as to warrant subsidies on the grounds of equity with other professionals. In fact, neither of these circumstances has occurred. The number of applicants to medical schools far exceeds the number of slots. The net present value of investment in medical education by specialist physicians exceeds that for law, business, and dentistry, although return on investment for primary care physicians trails these professionals (Weeks et al. 1994).<sup>8</sup>

Some have also argued that Medicare subsidies are necessary to ensure that disadvantaged students are able to select medicine as a career; that is, if residents were required to pick up the costs of training themselves, only the privileged could become doctors. Providing broad support for graduate medical education, however, is a rather blunt approach to ensuring diversity in the physician work force. A more effective approach to meeting this goal would be to fund individuals, rather than institutions, either through Medicare or other sources of federal support (for example, grants and scholarships under the Public Health Service Act).

An argument can be made that Medicare funding could once again be made responsive to work force concerns if subsidies were targeted, rather than being open-ended. Instead of ending Medicare support for clinical education because it has led to the overproduction of physicians, Medicare could attach conditions to its dollars to take some of the steps on which there is broad agreement—for example, training fewer physicians overall, providing training experiences in outpatient settings, and training physicians to locate in underserved areas. Based on this rationale, appropriate policy responses might include paying for fewer trainees, changing payments for the direct costs of GME from institution-specific per resident amounts to payments based on the national average, and permitting use of funds in settings other than hospitals and hospital-owned outpatient sites.

## **PUBLIC SUPPORT FOR GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS**

The two major proposals on GME financing in the 104th Congress both included financing from sources other than Medicare. Medicare restructuring legislation provided for appropriations from general revenues to support teaching hospitals and GME. Between fiscal years (FY) 1997 and 2002,

---

<sup>8</sup> Net present value reflects the cumulative value of educational investment per hour worked. This measure, unlike the internal rate of return, is not sensitive to early earnings. Because attorneys and business executives have relatively brief periods of training compared with physicians and thus higher early incomes, their rates of return are higher.



the amount specified in the bill was \$12.4 billion. Starting in FY 2003, the amount of general revenues appropriated was to have increased annually by growth in the gross domestic product. Legislation introduced by Senator Moynihan would have placed a 1.5 percent assessment on health insurance premiums to be deposited in a GME financing pool.

Using other sources of revenue to finance graduate medical education raises two questions: whether there is a different rationale for financing teaching hospitals or GME from general revenues (or other payers) than from Medicare dollars, and whether such differences imply different principles for distributing funds.

Medicare's current commitment to GME is made in the context of the total amount of money Medicare has available to spend on all aspects of the program; that is, a dollar not spent on GME is a dollar that could be spent on payments to other providers, benefits for beneficiaries, or budget savings. Appropriately, therefore, Medicare payments now go only to institutions that serve Medicare patients, and the level of payment is proportional to the institution's Medicare caseload. This means, however, that not all hospitals with training programs receive support for GME, freestanding children's hospitals being a notable exception.

General revenues, by contrast, could be distributed among training programs and teaching hospitals with regard to any criteria the Congress finds compelling. While a Medicare dollar not spent on GME can be spent only on Medicare services, general revenues are not obligated to any particular purpose; decisions about their use are made by the Congress in the context of all other competing federal priorities. The Congress could choose to support teaching hospitals generally as a means of ensuring the public's access to care in these settings or to maintain the viability of these institutions. It could support training programs generally to ensure sufficient physicians to meet the nation's health care needs. It could target support to those institutions that could not be expected to endure market competition but are nonetheless critical to maintaining the public health—for example, urban public hospitals. Or it could target support to training of certain types of health professionals who are needed but who the market will not support—for example, specialists in geriatrics.

## **CURRENT MEDICARE POLICY**

Graduate medical education is largely financed through patient care revenues generated by hospitals. The federal government is the largest single explicit financing source for graduate medical education through the Medicare program.<sup>9</sup> Other payers have less explicit mechanisms. Teaching hospital charges to private payers reflect the direct costs of GME (for example, residents' stipends), although these payers do not identify and separately pay for them.

---

<sup>9</sup> The federal government also supports residencies in hospitals run by the Departments of Veterans Affairs and Defense.

In Medicare's early years, GME was funded like other hospital services on a retrospective, reasonable cost basis. With the adoption of prospective payment, new policies were needed to ensure equitable payment for teaching hospitals. The costs of graduate medical education are now recognized under two mechanisms: (1) direct medical education payments to hospitals for residents' stipends, faculty salaries, administrative expenses, and institutional overhead allocated to residency programs; and (2) an indirect medical education adjustment.

In the early years of prospective payment, direct medical education payments were essentially a pass-through of costs related to training. Since the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), direct payments have been based on three factors: (1) hospital-specific per resident costs from the 1984 or 1985 cost-reporting years updated for inflation, (2) the number of full-time equivalent residents (FTEs), and (3) Medicare's share of inpatient days. Under OBRA93, the inflation adjustment for residents in nonprimary care fields was eliminated for fiscal years 1994 and 1995.<sup>10</sup> As a result, the per resident amount differs for primary care and other residents (Fishman 1996).

The hospital's per resident base amount is multiplied by the number of full-time equivalent residents during the payment period times Medicare's share of inpatient days. Residents beyond the initial period of residency (up to the minimum for board eligibility, not to exceed five years) are weighted as 0.5 FTEs. There is also a special exception that allows residents in accredited geriatrics training programs to be considered as 1.0 FTE for an additional two years.

The indirect medical adjustment, by contrast, is a hospital-specific percentage amount (based on the ratio of interns and residents per bed) added to the payment for each admission. As mentioned above, the IME adjustment was developed to compensate teaching institutions for their relatively higher costs thought to be associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services available only in teaching hospitals.

## **PROBLEMS WITH CURRENT POLICY**

The Congress appears interested in continuing support for GME as evidenced by legislation introduced by both Republicans and Democrats. This may be because of hospital dependence on GME payments (which amounted to over \$7 billion in fiscal year 1995), the broad distribution of Medicare payments across the nation, or the apparent lack of alternative financing sources.<sup>11</sup> The challenge now facing policymakers is how to redirect Medicare spending and correct the problems that have been

---

<sup>10</sup> Nonprimary care residents are defined as all specialties except family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics-gynecology.

<sup>11</sup> In fiscal year 1995, Medicare paid approximately \$2.3 billion in direct medical education payments and \$4.9 billion in indirect adjustments.

identified under the current payment methodology. Five problems are discussed below: (1) payment based on the number of residents in an institution, (2) payment for the direct costs of graduate medical education based on institution-specific historical costs, (3) payment primarily for training in inpatient settings, (4) lack of payment to teaching institutions when enrollees of Medicare managed-care plans are admitted to these hospitals, and (5) use of Medicare funds to support nursing education in diploma schools.

### **Payment Based on the Number of Residents**

Medicare payment for graduate medical education is proportional to the number of residents training in each institution. For direct medical education payments, there is a payment for each full-time equivalent resident. For the indirect adjustment, the add-on to per case payments increases as the ratio of interns and residents to beds in an institution increases.

Under both mechanisms, more residents results in more Medicare dollars flowing to the institution. As a result, hospitals have an incentive to organize patient care services around residents rather than other caregivers such as nurse practitioners, physician assistants, or staff physicians.

Medicare's rules could be changed so that payment is no longer proportional to the number of residents. Under the Medicare restructuring legislation proposed in the last Congress, this would have been achieved by basing payments to teaching hospitals on their historical share of direct and indirect payments. The implication is that hospitals that increase the number of trainees do so at their own expense; those that decrease the number of trainees are held harmless for this action. Implementing such changes will require methods of periodically rebasing payments so that hospitals do not receive payments into perpetuity based on the number of residents they had at one point in time.

The Health Care Financing Administration recently approved a demonstration in New York State that will break the link between Medicare payment and the number of residents. Under this demonstration, incentive payments totaling \$400 million over six years will be provided to 41 teaching hospitals in New York that reduce the number of residents they train either by 25 percent in the aggregate or by 20 percent if they improve primary care training (Rosenthal 1997).

### **Direct Medical Education Payments Are Highly Variable**

Since the passage of COBRA, direct medical education payments have been based on Medicare's share of hospital-specific per resident costs from the 1984 or 1985 cost-reporting years, updated for inflation. This formula has led to substantial variation in payments across hospitals, from a low of \$11,000 to more than \$100,000 per resident.<sup>12</sup> This variation is thought to reflect differences in

---

<sup>12</sup> The distribution for residents' stipends is much tighter, with more than 70 percent of hospitals reporting salary and fringe benefit costs ranging from \$20,000 to \$60,000.



accounting practices (for example, how overhead costs are allocated across departments) and inaccuracies in measuring the number of FTEs, rather than differences in the true costs of training (PPRC 1993). Other differences, for example, whether or not faculty physicians are employees of the hospital, also affect training costs. It is not clear, however, how much of this variation Medicare should support.

Variation in direct payments could be reduced by paying hospitals based on a standardized amount per resident.<sup>13</sup> Implementation questions concern whether this payment should be simply the national average payment; the national average adjusted by differences in local wage rates, specialty or other factors; or whether it should be derived by other means.

### **Payment to Hospitals**

A third problem with current Medicare policy is that payments may be made only to hospitals, despite the expressed need for physicians trained to practice in ambulatory settings and with specific competencies needed to practice effectively in managed-care organizations. Although residents do spend time in ambulatory settings, that time is only recognized for the purposes of Medicare direct medical education payment if the hospital “incurs all or substantially all” of the costs of training. Residents’ time spent outside the hospital can not be counted for purposes of the indirect medical education adjustment. It is not clear that counting residents’ time in outpatient settings for the purposes of the indirect medical education adjustment is appropriate. As noted earlier, the original rationale for the indirect adjustment was to recognize teaching hospitals’ higher costs, not to support education per se.

This policy does not reflect the changes that have occurred in GME since Medicare was enacted. Training no longer takes place exclusively in hospitals. Making payment primarily for time spent in inpatient settings thus creates a disincentive to move training to other sites such as outpatient clinics, nursing homes, and physician group practices. Moreover, hospitals are not held accountable for the use of the Medicare payments they receive. These dollars are fungible; once they flow into the hospital, they can be used for any purpose, not just the training of physicians. No empirical data exist to examine how hospitals are using these funds.

There are several ways to address these concerns. The disincentive to moving training outside the hospital could be removed by permitting all time to be counted for the purposes of either direct or indirect payments. Or payment could be extended to entities other than hospitals for the time residents spend in those settings. A complication in setting such payments is the lack of information about the costs of training in ambulatory sites. A third alternative, which would both permit training to be moved out of the hospital and introduce more accountability for use of medical education funds, would be to make payments for the full direct cost of medical education to training programs or consortia rather

---

<sup>13</sup> Such a change is possible even if all residents are not recognized for the purpose of Medicare payment.

than to hospitals.<sup>14</sup> This approach raises a number of implementation issues including how much should be paid and establishing the measure of Medicare activity for determining Medicare's share of costs.

### **Lack of Medicare Payment for Medicare Managed-Care Enrollees**

Growth of Medicare's risk-contracting program has raised two other related but distinct concerns about current policy for financing GME and teaching hospitals. First, capitation payments paid to risk plans are based on fee-for-service expenditures at the county level. Since fee-for-service expenditures include payments for GME (as well as for disproportionate share hospital payments), academic leaders have argued that managed-care plans are receiving payment for activities they are not obligated to support. Second, as mentioned above, teaching institutions are not permitted to count Medicare beneficiaries enrolled in managed-care plans when calculating their Medicare caseload for the purposes of receiving direct payments. The extent to which teaching hospitals now see Medicare managed-care enrollees is unclear.

The Commission recommended in 1995 and again in this report that medical education payments be removed from calculation of capitation payments, and that other methods be developed to pay for managed-care enrollees' use of teaching facilities or for training in managed-care sites.<sup>15</sup> This approach was taken by the Senate during the 104th Congress in its version of Medicare restructuring legislation, although it was dropped in the conference agreement. The final bill provided for payment to teaching institutions admitting Medicare managed-care enrollees but funded these payments from general revenues, rather than extracting them from capitation payments. In the 105th Congress, the Congress may substantially change the capitation payment methodology, breaking the link to fee-for-service expenditures. Such a change, however, would not address whether teaching hospitals should get paid more based on the number of Medicare managed-care enrollees admitted to their institutions or whether managed-care plans should be eligible for payments to recognize their teaching costs.

### **Nursing Education**

In addition to supporting the costs of graduate medical education, Medicare also provides cost-based reimbursement to hospitals for operating training programs in nursing and a variety of allied health fields, including cytotechnology, dietetics, hospital administration, inhalation therapy, medical records administration, medical technology, nurse anesthesia, occupational therapy, physical therapy, pharmacy, and X-ray technology. In 1994, Medicare paid an estimated \$248 million for nursing

---

<sup>14</sup> Some have suggested making payments to medical schools. It is important to recognize, however, that graduate medical education is not a function of medical schools. Some programs do have strong links to medical schools (for example, common faculty) but others do not.

<sup>15</sup> See Chapter 3 for a discussion of this and other issues concerning Medicare payments to managed-care plans.

education and \$83 million for allied health education under this provision (Aiken and Gwyther 1995).<sup>16</sup>

Medicare support for nursing education primarily supports diploma programs because of its origins as a mechanism to ensure equitable payment to hospitals for the costs they incur in treating Medicare patients.<sup>17</sup> There are questions, however, about whether Medicare should be supporting these programs given changes in nursing education and practice. When Medicare was enacted, 77 percent of nurses were trained in hospital-operated diploma programs. By 1990, though, less than 8 percent of graduates were from diploma schools (Aiken and Gwyther 1995). Moreover, the annual percentage of diploma-prepared graduates is expected to decline further, dropping to about 2.5 percent by the year 2020 (HRSA 1992). Nursing education at the graduate level receives no Medicare support despite increased demand for nurses trained as nurse practitioners and clinical nurse specialists. These disciplines did not even exist when the Medicare program was first implemented.

## **IMPLICATIONS OF TRUST FUND FINANCING**

Legislation considered by the Congress in 1995 would have substantially changed Medicare policy. Essentially, these proposals would have taken the money Medicare would have otherwise spent on direct and indirect medical education payments and put them in a trust fund with other revenues (either general federal revenues or proceeds from a tax on health insurance premiums). These funds would then have been allocated among teaching hospitals and other entities based on principles other than hospital costs and admissions.

There are several implications of financing graduate medical education and teaching hospitals from a trust fund. First, the existence of a trust fund creates the opportunity to correct all the problems in current policy outlined above. Spending can be oriented for specific purposes, such as training in ambulatory settings or for training in specific specialties. Or it can be structured to be neutral with respect to the type and setting of training (for example, permitting hospitals to count all residents' time, regardless of setting, for the purposes of payment).

A second implication is that a trust fund shifts financing from an open-ended entitlement to a fixed amount of funding. Under current law, the amount paid per resident is fixed, but total funding increases with increases in the number of residents. A trust fund could be structured so that the total

---

<sup>16</sup> A number of professional organizations have raised questions about whether Medicare should be supporting education only in these fields or in other health professions. They argue that Medicare should be supporting education of the range of health professionals qualified to provide services to Medicare beneficiaries. This chapter does not address this broad policy issue.

<sup>17</sup> Hospitals may also receive reimbursement for the costs associated with clinical training of the nursing programs they do not operate under certain circumstances. These include if (1) the provider was reimbursed for clinical training costs on or before October 1, 1989; (2) the provider's portion of allowable clinical costs is less than that in the previous period; (3) the provider benefits from supporting clinical education; and (4) costs to the provider do not exceed those if the provider actually operated the program.



amount of funding is fixed, and the payment per resident is variable (for example, decreasing as the number of residents grows).

Third, financing from general revenues creates a new political dynamic for stakeholders. Some argue that, given concerns about the solvency of the Part A trust fund (from which direct and indirect payments are made), infusion of general revenues will insulate teaching institutions from stringent Medicare cuts. Others are concerned, however, that reliance on general revenues is a risky strategy. Currently, Medicare payments are an entitlement; there is always enough money for those eligible. General revenues, however, are subject to the vagaries of the appropriations process and could be whittled away over time as teaching institutions are forced to compete with others for scarce discretionary funds.

Finally, the existence of a trust fund creates an administrative structure that could be used for accepting and distributing revenues from other payers. Although the current Congress does not appear inclined to compel other payers to contribute to GME financing, leaders in academic medicine see creation of a federal trust fund as an important first step in securing broader support.

It is important to note that at least some of the policy goals envisioned either under Medicare restructuring bills or Senator Moynihan's proposal could be accomplished by more modest changes in Medicare policy than creation of a trust fund. For example, a trust fund is not necessary for correcting any of the five problems with current policy identified earlier.

In addition, it is possible to reduce the number of trainees receiving public support without creating a trust fund. This may be easier (administratively and politically) to accomplish with a trust fund, however, because explicit decisions do not have to be made about who not to fund. Instead if the number of trainees increases above the desired level, amounts paid per resident drop.

## **WORK PLAN**

As the Commission works with the Congress in the months ahead, it will continue to explore the implications of making payments from a GME and teaching hospital trust fund. Issues to be considered include which entities should be eligible to receive trust fund payments and methods to ensure their accountability. The Commission will also analyze the implications of paying hospitals based on their historical share of Medicare dollars, other options for allocating trust fund revenues, and how to set allocations to accommodate change over time in where training occurs. The implications of some alternatives, for example, the distributional consequences at the hospital level of changing Medicare payments, will be modeled using data from Medicare cost reports and the Health Care Financing Administration's Intern and Resident Information System.

## REFERENCES

- Aiken, Linda H., and Marni E. Gwyther, "Medicare Funding of Nurse Education: The Case for Policy Change," *Journal of the American Medical Association* 273(19):1528-1532, May 17, 1995.
- Anderson, Gerard F., *Financing Clinical Education: A Law Firm Approach* (Baltimore: Center for Hospital Finance and Management, Johns Hopkins Medical Institutions, undated).
- Association of American Medical Colleges, *American Medical Education: Institutions, Programs and Issues* (Washington, DC: November 1992)
- Association of American Medical Colleges, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 23, 1995.
- Committee on Ways and Means, U.S. of Representatives, *Report on H.R. 6675, to provide a hospital insurance program for the aged under the Social Security Act with a supplemental health benefits program and an expanded program of medical assistance, to increase benefits under the old age, survivors, and disability insurance system, to improve the federal-state public assistance program, and for other purposes*, 89th Congress, 1st session, House Report, No. 213 (Washington, DC: U.S. Government Printing Office, 1965).
- Commonwealth Fund, *Report of the Task Force on Academic Health Centers: Prescription for Change* (New York: 1985).
- Epstein, Arnold M., "U.S. Teaching Hospitals in the Evolving Health Care System," *Journal of the American Medical Association* 273(15): 1203-1207, April 19, 1995.
- Fishman, Linda, *Medicare Payments with an Education Label: Fundamentals and the Future* (Washington, DC: Association of American Medical Colleges, 1996).
- Gurnick, Dolores A., Louis P. Garrison, Thomas T.H. Wan, and Vera Kurlantzick, *Alternative Approaches for Graduate Medical Education Payment Through Medicare: Background, Issues, and Options*, unpublished report to the Health Care Financing Administration under cooperative agreement No. 99-C-99168/3-01, Project HOPE HCFA Health Policy Research Center, Richmond, VA, and Chevy Chase, MD, February 8, 1991.
- Health Resources and Services Administration, Department of Health and Human Services, *Health Personnel in the United States, Eighth Report to Congress 1991*, DHHS Publication No. HRS-P-OD-92-1 (Rockville, MD: September 1992).
- Iglehart, John K., "Health Policy Report: Rapid Changes for Academic Medical Centers. Second of Two Parts," *New England Journal of Medicine* 332(6):407-411, February 9, 1995.

- Lee, Philip, Lauren LeRoy, Janice Stalcup, and John Beck, *Primary Care in a Specialized World* (Cambridge: Ballinger Publishing Co., 1976).
- Neville, Sarah, "Nation's University Hospitals Struggle to Find Cure for Economic Ills," *Washington Post*, September 10, 1995, p.A-22.
- Physician Payment Review Commission, *Annual Report to Congress*, 1993 (Washington, DC: 1993).
- Physician Payment Review Commission, *Annual Report to Congress*, 1994 (Washington, DC: 1994).
- Prospective Payment Assessment Commission, unpublished table, January 1997.
- Reinhardt, Uwe E., *Health-Manpower Forecasting: The Case of Physicians*, unpublished paper, March 1990.
- Reinhardt, Uwe E., "Planning the Nation's Health Workforce: Let the Market In," *Inquiry* 31(3):250-263, Fall 1994.
- Rosenthal, Elisabeth, "U.S. to Pay New York Hospitals Not to Train Doctors, Easing Glut," *New York Times*, February 18, 1997, p. A-1.
- Swanson, August G., "Graduate Medical Education: Its Past, Its Present and Its Future," in *Taking Charge of Graduate Medical Education: To Meet the Nation's Needs in the 21st Century*, proceedings of a conference sponsored by the Josiah Macy, Jr. Foundation, February 19-22, 1992, Naples, FL.
- Weeks, William B., Amy E. Wallace, Myron M. Wallace, and H. Gilbert Welch, "A Comparison of the Educational Costs and Incomes of Physicians and Other Professionals," *New England Journal of Medicine* 330(18):1280-1286, May 5, 1994.





# Managing Health Care For Dually Eligible Beneficiaries

Elderly or disabled people who are jointly enrolled in Medicare and Medicaid are called dual eligibles. As a group, they are poor and require a great deal of care because of their propensity to be institutionalized, disabled, and functionally impaired. As heavy consumers of health care services, they account for a disproportionate share of spending by Medicare, their primary insurer, and by Medicaid, which covers most of the costs for long-term care. Furthermore, dually eligible beneficiaries are dependent on coordination between these two programs for the financing and delivery of their care.

Until recently, this group has not received much attention in Medicare or Medicaid policy. As the Congress deliberates possible restructuring of both programs, it should consider how changes in either one might affect this vulnerable population.

The increasing use of managed-care arrangements in Medicare and Medicaid affords significant opportunities to improve care for dual eligibles. At the same time, it creates even greater challenges to coordination between the two programs. Current efforts, under which each program's prepaid arrangements operate individually, are not optimal. For example, these arrangements can furnish health care providers incentives to shift costs between Medicare and Medicaid, rather than to improve efficiency and quality of care overall. Demonstration projects have tested strategies for better coordinating the financing and delivery of care for dual eligibles who qualify for nursing home care, but only a small fraction of the dually eligible population may be served through these projects. Other ways to meet the needs of this diverse group need to be explored.

*This chapter includes:*

- *Information describing the dually eligible population*
- *Issues raised by enrollment of dual eligibles in managed care*
- *Policy directions for Medicare and Medicaid*

## Recommendations

*Development of proposals to restructure Medicare and Medicaid should explicitly take into account their implications for disabled and elderly beneficiaries who are entitled to benefits from both programs. Proposals should be assessed in terms of their effect on the potential for coordinating the financing and delivery of care.*

*The Health Care Financing Administration, in conjunction with state Medicaid agencies, should develop and test improved ways to coordinate the financing and delivery of care for beneficiaries eligible for both Medicare and Medicaid. Promising approaches should be tested through demonstration projects, and the results should be disseminated.*

This chapter presents the Commission's initial work on issues relating to dual eligibility. It provides a foundation for further work to consider policy changes in Medicare, Medicaid, or other areas that could improve the ability to finance and deliver care for dual eligibles. The chapter begins by describing the dually eligible population using the limited data available. It then looks at the issues raised by enrollment of dual eligibles in managed care from the perspective of the beneficiaries, state Medicaid programs, Medicare, and health plans. It concludes with a discussion of possible directions for Medicare and Medicaid policy.

## BACKGROUND ON DUAL ELIGIBILITY

This section provides background information on dual eligibles. It describes dual eligibility and the characteristics of the dually eligible population. It then presents estimates of Medicaid spending on the elderly, who make up about two-thirds of this group. That discussion is followed by consideration of managed-care arrangements available for serving these beneficiaries.

As with most issues pertaining to the Medicaid program, data on dual eligibles are scarce and problematic. Information on this group is limited by variations among states in the breadth and scope of their Medicaid programs as well as inaccuracies in state reporting.<sup>1</sup> Because of these limitations, many descriptive statistics on dually eligible beneficiaries are estimates.

---

<sup>1</sup> Better data are expected to be available in the near future, however. The Health Care Financing Administration has initiated a data link project that merges Medicare and Medicaid data for the dually eligible population.



## **The Meaning of Dual Eligibility**

Dual eligibles are Medicare beneficiaries who are also entitled to obtain benefits through their state Medicaid programs because they qualify as categorically or medically needy.<sup>2</sup> Where state Medicaid programs offer additional health care services not covered by Medicare, dual eligibles are entitled to those benefits. Such services vary by state, but often include prescription drug coverage; nursing home and other institutional care; home care; dental care; mental health care and other therapy; eye care; and transportation to and from providers.

Because Medicaid is considered a payer of last resort, Medicare is always the primary insurer for those enrolled in both programs. In practice, this means that Medicare pays for all services in its benefits package, and that Medicaid acts much like a supplemental insurance policy, paying for the Medicare deductible, coinsurance, and any services in the state's Medicaid benefits package that Medicare does not cover.

### **Other Medicare Beneficiaries Covered by Medicaid**

Besides dual eligibility, other programs have been developed to help improve access to care for needy Medicare beneficiaries. Federal law requires states to help those who meet eligibility criteria for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs. Medicare beneficiaries whose incomes and resources are below federally established levels qualify as QMBs or SLMBs.<sup>3</sup> For QMBs, states are required to pay the Medicare Part B premiums (and Part A premiums for the small percentage of beneficiaries who would otherwise have to pay them), and to cover Medicare coinsurance and deductibles (Table 19-1). For SLMBs, states are required to pay only the Medicare Part B premiums.

Many, but not all, dually eligible beneficiaries are also QMBs or SLMBs.<sup>4</sup> Most dual eligibles who are categorically needy also qualify as QMBs or SLMBs, but many of those who obtain Medicaid on the basis of medical neediness exceed the income or resource limits for these designations.

---

<sup>2</sup> All states provide Medicaid coverage for Medicare beneficiaries who are categorically needy according to income and asset standards. As of 1995, 40 states provided such coverage to the medically needy: those whose incomes or resources exceed standards for cash assistance but who meet a separate state-determined income standard and are also aged, disabled, or a member of a family with dependent children.

<sup>3</sup> QMBs are Medicare beneficiaries whose incomes are at or below 100 percent of the federal poverty level. SLMBs are those whose incomes are under 120 percent of that level. Both QMBs and SLMBs cannot have resources exceeding 200 percent of the amount allowed under the Supplemental Security Income program.

<sup>4</sup> Qualified Disabled and Working Individuals (QDWIs), whose Medicare Part A payments are made by states, are often discussed in conjunction with QMBs and SLMBs. QDWI participation requirements disallow those who are eligible for Medicaid. Therefore, the QDWIs are never dually eligible and are not discussed in this chapter.

**Table 19-1. Coverage of Medicare Premiums, Cost Sharing, and Additional Benefits by State Medicaid Programs**

Medicare Beneficiary Group <sup>a</sup>	Part A Premiums	Part B Premiums	Medicare Cost Sharing <sup>b</sup>	Medicaid Benefits
Dually Eligible	State option	State option	State option	Yes
Qualified Medicare Beneficiary	Yes	Yes	Yes	No
Specified Low-Income Medicare Beneficiary	No	Yes	No	No

SOURCE: Physician Payment Review Commission compilation of information from the Congressional Research Service 1993.

<sup>a</sup> Medicare beneficiary groups are not mutually exclusive. A beneficiary may, for example, be both dually eligible and a Qualified Medicare Beneficiary.

<sup>b</sup> Cost sharing includes Medicare coinsurance and deductibles. States, at their option, may also cover Medicare risk-plan premiums.

### **Medicaid Payment of Medicare Premiums**

All states pay the Medicare premiums, or buy in to Medicare, on behalf of all or most of their dually eligible beneficiaries.<sup>5</sup> Because states cannot claim federal matching payments for any Medicaid expenditure that could otherwise have been a Medicare expenditure, they have strong financial incentives to ensure that their dually eligible beneficiaries have Medicare Part B coverage. Although all states now have buy-in arrangements for their QMBs and categorically needy dually eligible beneficiaries, only 14 states have such arrangements for medically needy dually eligible beneficiaries.<sup>6</sup> States receive federal matching assistance for paying the Part B premium for QMBs, SLMBs, and categorically needy beneficiaries (who they are required to cover), but not for the medically needy (who they can cover at their option).

### **Characteristics of the Dually Eligible Population**

Medicare enrollment in 1995 stood at approximately 37 million beneficiaries, while Medicaid enrollment exceeded 35 million. About 5.4 million people, or 15 percent of each program's enrollment, were enrolled in both Medicare and Medicaid. Roughly two-thirds of the dually eligible beneficiaries were elderly, while the rest were disabled.

---

<sup>5</sup> The term buy-in refers to the arrangements states generally make for paying Medicare premiums on behalf of those they are required or choose to cover. Under buy-in arrangements, states pay beneficiaries' Medicare premiums directly to the Department of Health and Human Services.

<sup>6</sup> Medically needy beneficiaries can include the Medicare premiums and cost-sharing payments that they make in calculating their "spend down," the amount they must spend on medical expenses out-of-pocket in order to attain Medicaid eligibility.

Data from the 1995 Medicare Current Beneficiary Survey permit comparing dually eligible beneficiaries with other Medicare beneficiaries (Table 19-2). The data show significant differences in the characteristics of these two groups.

**Table 19-2. Characteristics of Dually Eligible Beneficiaries and Other Medicare Beneficiaries, 1995 (percentage)**

Characteristic	All Beneficiaries	Dually Eligible	Other
Percentage of Medicare Population	100.0	14.6	85.4
Female	56.9	64.1	55.7
Age			
Under 65 (disabled)	11.0	30.6	7.6
65 to 84	78.1	54.3	82.2
85 or older	10.9	15.1	10.2
Race			
African American	9.1	24.2	6.7
White	89.0	71.0	91.9
Other	1.9	4.8	1.4
Covered Under Part B Buy-In	14.1	81.5	2.6
With Private Insurance	72.7	16.8	82.2
With at Least One Month HMO Enrollment	10.4	4.2	11.5
Institutionalized	5.6	16.8	4.1
Functionally Impaired	18.8	35.7	15.9
Health Status			
Excellent	16.2	7.2	17.7
Very good	25.8	13.3	27.9
Good	29.5	29.2	29.6
Fair	19.4	31.8	17.3
Poor	9.1	18.5	7.5

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

NOTE: Dual eligibles are defined as Medicare beneficiaries who reported being covered by Medicaid at any time during the year prior to the interview.

Dually eligible beneficiaries differed from others in demographic characteristics and health status. They were more likely to be female and nonwhite. They were also likelier to be disabled, functionally impaired, among the oldest old (85 or older), and institutionalized. A higher percentage of dual eligibles reported being in poor health, and fewer reported being in excellent health.



Dual eligibles also differed from other Medicare beneficiaries in other respects. About 82 percent were covered under state buy-in arrangements, compared with 3 percent of other beneficiaries.<sup>7</sup> Only 17 percent reported having private insurance in addition to Medicare and Medicaid, compared with 82 percent of other beneficiaries.<sup>8</sup> Dual eligibles were three times less likely than other beneficiaries to belong to a Medicare managed-care plan.

### Medicaid Spending for Elderly Beneficiaries

Although Medicaid serves as a supplementary policy for most of its elderly and many of its disabled beneficiaries, program spending averages for these groups are much higher than they are for others.<sup>9</sup> Average Medicaid payments per beneficiary in 1994 were \$8,332 for the elderly and \$7,750 for disabled adults and children. These averages contrast with Medicaid averages of \$1,791 for nonelderly, nondisabled adults and \$1,006 for nondisabled children (Table 19-3).

**Table 19-3. Enrollment of Medicaid Beneficiaries and Medicaid Expenditures for Services, by Eligibility Group, 1994**

	Total	Children	Adults	Aged	Disabled	Other
Number of Beneficiaries (millions)	35.1	17.2	7.6	4.0	5.5	0.8
Percentage of Beneficiaries	100.0	49.1	21.6	11.5	15.6	2.2
Percentage of Spending for Services	100.0	16.0	12.6	31.0	39.1	1.3
Expenditures for Services (billions of dollars)	108.3	17.3	13.6	33.6	42.3	1.5
Expenditures for Services per Capita (dollars)	3,085	1,006	1,791	8,332	7,750	1,875

SOURCE: HCFA 1996.

Medicaid spending estimates for the entire dually eligible population are not available, but data on the elderly suggest the importance of this group in Medicaid outlays. Of \$108.3 billion total state and federal spending on Medicaid services in 1994, \$33.6 billion went for services to elderly beneficiaries

<sup>7</sup> Many of the dual eligibles who are not covered under buy-in arrangements are those who qualify for Medicaid because they are medically needy. Beneficiaries who are not dually eligible but who are covered under such arrangements include some QMBs and SLMBs.

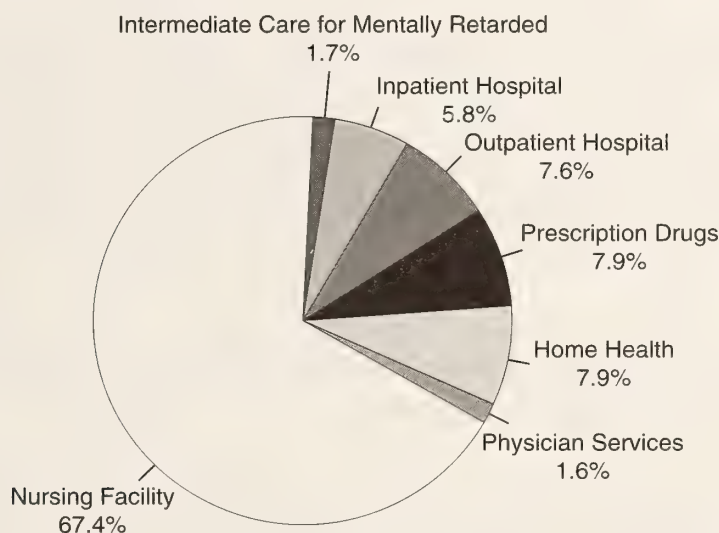
<sup>8</sup> Some beneficiaries enrolled in Medicare or Medicaid managed care may be included in this group. Therefore, the survey finding on the percentage who are privately insured does not necessarily represent only those beneficiaries who have a Medigap policy or an employer-sponsored supplemental policy.

<sup>9</sup> Nearly all of the 4.0 million elderly Medicaid beneficiaries in 1994 were also enrolled in Medicare. A much smaller percentage (approximately one-fourth overall, although the percentage is likely to vary considerably across states) of the 5.5 million disabled adults and children who were Medicaid beneficiaries in 1994 were also eligible for Medicare. This difference is due, in part, to the fact that people must be entitled to disability benefits for at least 24 months before they are eligible for Medicare.

(Table 19-3).<sup>10</sup> In other words, the 12 percent of the Medicaid population who were elderly (nearly all of whom were dually eligible) accounted for 31 percent of Medicaid expenditures for services.

Nursing home care plays a big role in Medicaid spending, overall and for the elderly in particular. Such care accounted for a quarter of total Medicaid payments for services in 1994; more than 80 percent of that care was provided to elderly beneficiaries (HCFA 1996). Nursing facility payments accounted for 67 percent of Medicaid spending on services for the elderly (Figure 19-1).

**Figure 19-1. Medicaid Payments for the Aged, by Type of Service, 1994**



SOURCE: HCFA 1996.

### Managed-Care Arrangements for Dual Eligibles

Managed care is becoming increasingly common in both Medicare and Medicaid. More than 11 percent of Medicare beneficiaries are now enrolled in health plans that are at full financial risk, as are 27 percent of Medicaid beneficiaries. An additional 12 percent of Medicaid beneficiaries are enrolled in primary care case management arrangements (under which physicians are paid a fee for managing care but do not bear risk) or in health plans that are paid on a partial-risk basis. About 2 percent of Medicare beneficiaries are enrolled in managed-care plans that are paid on a cost basis.

Dually eligible beneficiaries may receive managed care through either the Medicare or Medicaid programs, or through both. Managed-care enrollment of dually eligible beneficiaries depends on a

---

<sup>10</sup> This spending does not include capitation payments to prepaid health plans or any Medicaid spending other than for services. Total federal and state Medicaid expenditures in 1994 were \$143.2 billion (HCFA 1996).

number of factors, including the availability of participating health plans in beneficiaries' geographic area and individual state Medicaid program policies.

**Medicare Managed Care.** As Medicare beneficiaries, dual eligibles are entitled to enroll in Medicare managed-care plans as long as they live in an area served by a plan.<sup>11</sup> Risk and cost-contracting plans provide the full Medicare benefits package, and many risk plans provide additional benefits, like prescription drug coverage or preventive services.<sup>12</sup> While enrolled in a risk plan, beneficiaries are locked into their plan's network of providers, meaning that Medicare will not cover any services obtained outside the plan on a fee-for-service basis.<sup>13</sup> Enrollees have an opportunity to disenroll from their plan and either enroll in another or return to fee for service on a monthly basis.

Dually eligible beneficiaries enrolled in Medicare managed-care plans also receive assistance through their state Medicaid program. They are entitled to obtain through Medicaid any additional services that Medicaid covers but that the plan does not. These Medicaid benefits can be furnished on either a prepaid or fee-for-service basis, and may or may not be available through the same provider or plan that supplies the Medicare services. For those dually eligible who also qualify as QMBs, Medicaid covers any coinsurance or deductibles charged by the Medicare managed-care plan. States have the option to pay the Medicare managed-care plan premium, if any is charged to enrollees.<sup>14</sup>

Dual eligibles are currently less likely than other beneficiaries to enroll in Medicare managed-care plans. Only 4 percent belonged to a Medicare managed-care plan at some point in 1995, compared with 12 percent of other beneficiaries (Table 19-2).<sup>15</sup>

**Medicaid Managed Care.** State Medicaid programs have begun to turn to managed care as a way to reduce the growth in program spending that also offers opportunities to improve access and quality. Despite considerable variety in the managed-care arrangements state Medicaid programs are using, they can be roughly categorized in four groups: health maintenance organizations, primary care case management, prepaid health plans, and health insuring organizations.<sup>16</sup> Medicaid managed-care plans

---

<sup>11</sup> Exceptions are those who qualify for Medicare because of end-stage renal disease and those in a hospice.

<sup>12</sup> Because Medicare spending for dual eligibles is higher, on average, than for other beneficiaries, Medicaid eligibility is taken into account in the formula for making capitation payments to Medicare risk plans. A recently released study by the Department of Health and Human Services Office of the Inspector General reported that Medicare risk plans often misclassify these beneficiaries, and have therefore received significant overpayments (OIG 1996).

<sup>13</sup> The Health Care Financing Administration now allows plans to offer a point-of-service option.

<sup>14</sup> Two-thirds of Medicare risk plans are now offered at no premium cost to the beneficiary. For additional information on Medicare risk-contracting plans and enrollment, see Chapter 2.

<sup>15</sup> Beneficiaries covered by state buy-in arrangements also appear to be underrepresented in Medicare risk plans. A Commission-sponsored study of Medicare risk-plan enrollees and disenrollees found that only 4 percent of risk-plan enrollees were covered under a buy-in arrangement in 1996 (Nelson et al. 1996).

<sup>16</sup> See Chapter 20 for further discussion of the types of managed-care arrangements used in Medicaid.



that are at risk for the cost of care provided often are not responsible for institutional care or long-term home health care, services that states usually contract for separately.<sup>17</sup>

State Medicaid programs have different options for making these various types of managed-care arrangements for their beneficiaries. A state can operate a managed-care program without seeking any waivers of federal requirements if the program has voluntary enrollment, operates statewide, meets enrollment composition rules, and provides comparable benefits to all eligibility groups that the state must cover by federal law. In order to run a program under alternative rules, states must obtain one of two different types of federal waivers—commonly known as 1915(b) waivers or 1115 waivers.<sup>18</sup>

States are seeking waivers of federal Medicaid requirements to try new approaches for providing care to beneficiaries, including dual eligibles. States' initial efforts were concentrated on the low-income families who constitute the majority of Medicaid beneficiaries. Increasingly, however, states are beginning to face the challenges of elderly and disabled Medicaid beneficiaries, many of whom have chronic needs for specialized or resource-intensive care. There is little experience among managed-care plans in caring for these vulnerable groups, however, and the focus of traditional plans on preventive care and health maintenance may not be the most appropriate for these beneficiaries.<sup>19</sup>

Under a waiver, states may obtain permission from the Health Care Financing Administration (HCFA) to require dual eligibles to obtain their Medicaid services through a managed-care program. They cannot, however, require dually eligible beneficiaries to obtain their Medicare services through the Medicaid managed-care plan. If that plan also participates in Medicare as a risk contractor, dually eligible beneficiaries could choose to enroll as a Medicare beneficiary and obtain all of their care through the plan. In that case, the plan would receive capitation payments from both Medicare and Medicaid. Otherwise, dually eligible beneficiaries could enroll in another plan that participates in Medicare, or could obtain Medicare benefits on a fee-for-service basis.

**Medicaid Programs for the Elderly.** A 1996 survey by the National Academy for State Health Policy (1997) showed that 20 states had risk-based managed-care programs for their elderly Medicaid beneficiaries who were not institutionalized; 9 also enrolled at least some of their institutionalized elderly. For 13 states, enrollment was mandatory for at least some elderly beneficiaries.

---

<sup>17</sup> That is likely to change in the near future, however, as states have shown significant interest in including long-term care in their risk contracts. Health plans often lack experience in providing this care, however, and have been reluctant to accept risk in this area.

<sup>18</sup> Section 1915(b) waivers are the most commonly used approach for obtaining exemptions to federal Medicaid requirements. A state seeking a 1915(b) waiver must demonstrate that its proposed program would be cost effective and that access to quality care would not be impaired. Section 1115 waivers are approved on a demonstration basis where states propose to test unique and innovative approaches to health care financing and delivery. Unlike Section 1915(b) waivers, these waivers are generally not renewable. For additional information, see Chapter 18 of the Commission's 1996 annual report and Chapter 8 of the 1995 annual report.

<sup>19</sup> See Chapter 5 for information on potential strategies for promoting access to care for vulnerable groups in Medicare managed-care plans.

**Programs for the Disabled.** As of February 1996, 12 of the 17 states that had prepaid managed-care programs for their disabled beneficiaries also enrolled at least some who were dually eligible (GAO 1996).<sup>20</sup> In four of those states—Arizona, Oregon, Tennessee, and Utah—disabled dually eligible beneficiaries were required to enroll. In seven others, such beneficiaries could participate in programs that were also open to voluntary enrollees from the general Medicaid population. In Wisconsin, disabled dually eligible beneficiaries could choose to enroll in a state program designed exclusively for disabled persons. A number of other states have pending or approved Medicaid waivers that would move disabled beneficiaries into managed-care arrangements, several of which would involve some groups within the dually eligible population.

## **ISSUES IN MANAGING CARE AND BENEFITS FOR DUAL ELIGIBLES**

The growth of managed care in Medicare and Medicaid provides new opportunities for improving the delivery of care for dual eligibles and poses new challenges for coordinating their benefits. These beneficiaries may face problems unique to their eligibility status as Medicare and Medicaid increasingly turn to prepaid delivery systems and as reform of both programs is contemplated in the Congress. As a group, dual eligibles also present specific challenges for both Medicare and state Medicaid programs, as well as for the health plans that serve them. The types of issues faced by these stakeholders are sketched out below. Where possible, examples of approaches now being used to address or avert potential problems are presented.

### **Beneficiaries' Perspective**

Both Medicare and Medicaid managed care offer special opportunities for dual eligibles. Medicare managed care has the potential to provide more comprehensive and better coordinated care for this population than would be available for them under uncoordinated fee-for-service Medicare and Medicaid arrangements. Dual eligibles are currently underrepresented in the Medicare risk program, however. Whether that is because of differences in opportunity (real or perceived) or in preferences is unknown.<sup>21</sup> Dual eligibles are also only beginning to be enrolled in Medicaid managed care, although their participation is increasing under state waiver programs. Waivers offer Medicaid programs the flexibility to provide managed-care arrangements that are targeted to the special needs of elderly and disabled dually eligible beneficiaries, but development of such programs is only now getting under way.

---

<sup>20</sup> Three of the 12 states allowed Medicaid managed-care enrollment by disabled dually eligible beneficiaries only if they obtained Medicare services on a fee-for-service basis. In addition, most states excluded at least some of the institutionalized populations. Most also excluded beneficiaries who were recipients of home and community-based services who would need to be institutionalized if these services were not available.

<sup>21</sup> Because of their greater needs for care, dual eligibles may be reluctant to change physicians, which can be necessary when enrolling in a health plan that offers a designated network of providers. Additionally, because Medicaid serves as wraparound or supplemental coverage, dual eligibles may be less attracted by the lower out-of-pocket costs and increased benefits that many Medicare risk plans provide.



Under current arrangements in which Medicare and Medicaid coverage and benefits are separately administered for dual eligibles, beneficiaries may obtain care under a variety of arrangements. Some or all of these arrangements may be confusing or challenging for dually eligible beneficiaries, and few optimize the coordination of care and benefits. For example, some dually eligible beneficiaries may get their Medicare benefits through managed-care arrangements and their Medicaid benefits on a fee-for-service basis, or vice versa. Some may get both their Medicare and Medicaid through managed-care arrangements, but through two separate delivery systems. Only a minority now have the option to belong to one managed-care plan that provides both Medicare and Medicaid benefits for its dually eligible enrollees.

Some dually eligible beneficiaries may face disruptions in the continuity of their care because of the relationship between Medicaid and Medicare. That is particularly likely for disabled beneficiaries who become dually eligible after the two-year Medicare waiting period. Disabled Medicaid beneficiaries in prepaid programs designed especially to meet their needs may become ineligible for these programs once they become eligible for Medicare.

### **Health Plans' Perspective**

The types of challenges managed-care plans face in dealing with the dual eligibles include coordinating Medicare and Medicaid requirements, coverage, and financing. Plans that do not participate in both programs are less able to accept risk and to manage the full range of services needed by their dually eligible enrollees. Plans that do contract with both are also likely to experience complications associated with enrolling dual eligibles.

For dually eligible beneficiaries to obtain all of their health care on a prepaid basis, a plan must contract with both Medicare and Medicaid, and must thus meet each program's participation requirements. Not only do these requirements differ, they sometimes pose obstacles that discourage plans from contracting with both programs. For example, the combined enrollment of Medicare and Medicaid beneficiaries cannot exceed 50 percent of total membership in Medicare managed-care plans. By contrast, Medicaid managed-care plans are prohibited from exceeding a 75 percent enrollment of the publicly insured. Medicare plans whose Medicare enrollment is approaching 50 percent may therefore be unwilling or unable to participate in Medicaid as well.

Even where plans participate in both Medicare and Medicaid—and can thus provide the full range of care for dually eligible enrollees—there may be significant problems because of differences in each program's requirements. Dissimilar requirements for enrollment composition, lock-in arrangements, and enrollment/disenrollment procedures may be particularly problematic. For example, a dually eligible beneficiary who enrolls in one plan for both Medicare and Medicaid coverage is likely to have his or her enrollment effective on different dates. This poses considerable administrative burdens on plans that will need to bill for some care on a fee-for-service basis during the interim period.<sup>22</sup> To

---

<sup>22</sup> Medicare risk-plan enrollment may be particularly problematic because it often takes up to 60 days.



address this issue, some state programs have sought a retroactive Medicare enrollment option for plans serving dual eligibles. For example, for Minnesota's Senior Health Options program, which began enrolling beneficiaries in early 1997, the state worked with HCFA to develop a single set of enrollment, grievance, and quality assurance procedures for plans serving dual eligibles.

## State Issues

One limitation states face in attempting to structure managed-care approaches for dual eligibles is the inflexibility of Medicare requirements for health plans that serve Medicare beneficiaries. Under current law, states must contract with plans participating in Medicare for dually eligible beneficiaries to have the option to obtain all of their health care through one health plan on a prepaid basis. Plans are often reluctant to contract with both Medicare and Medicaid, however, because of conflicting requirements.<sup>23</sup> In addition, states may prefer to contract with the Medicaid plans with which they have worked in the past, or with providers that specialize in caring for disabled, chronically ill, frail, and institutionalized persons. Because Medicare risk-plan enrollees are younger, healthier, and less likely to be disabled than other Medicare beneficiaries, many risk plans may lack experience in caring for the most vulnerable groups.<sup>24</sup>

The need to contract with Medicare risk contractors is particularly problematic for states that have no (or few) Medicare risk plans. Minnesota—a state where Medicare risk-plan penetration is relatively low but commercial managed-care penetration is high—has obtained the first waiver that permits Medicare capitation payments to be made to plans not participating in the risk program. Minnesota's waiver allows the state to purchase both Medicare and Medicaid services on behalf of its dually eligible beneficiaries, regardless of whether the plan is a Medicare risk contractor. Plans enrolling dual eligibles enter into a single contract with the state to provide the full range of Medicare and Medicaid benefits. They receive a capitation payment from HCFA to cover Medicare services, and a separate one from the state to cover Medicare cost-sharing and Medicaid services.

The Medicare waiver approach has not been widely used, however, partly because of HCFA's narrow interpretation of its legislated authority to waive Medicare program requirements. Minnesota is the only state with a waiver permitting 30-day Medicare lock-in to plans that do not participate in Medicare. Dually eligible beneficiaries who voluntarily enroll are restricted to their plan's network for both Medicare and Medicaid services, just as Medicare risk-plan enrollees are locked in to their plan's network. Two other states, Arizona and Oregon, now have effective lock-in arrangements under waivers that allow the states not to pay Medicare cost sharing on services obtained by dually eligible beneficiaries outside the networks of the Medicaid managed-care plans that serve them. HCFA has

---

<sup>23</sup> Plans also may be reluctant to contract with Medicare or to invest in programs to serve dual eligibles because of concerns about the volatility of Medicare payments to plans over time and uncertainty regarding changes in payment methodology that are being contemplated by policymakers. See Chapter 3 for a discussion of Medicare risk-plan payment issues.

<sup>24</sup> See Chapters 4 and 5 for discussion of risk selection in the Medicare risk program.

indicated that it will not authorize such arrangements in the future because of reluctance to infringe on Medicare beneficiaries' rights to choose their providers.<sup>25</sup> Without a lock-in, states will need to ensure that their programs for their dual eligibles are sufficiently attractive to hold enrollees. Otherwise, it may be difficult for states to find plans willing to accept responsibility for the costs and quality of care received by dually eligible enrollees.

States with sufficient numbers of Medicare managed-care plans have more options. Oregon, for example, which has one of the highest Medicare risk-plan penetration rates in the country, has developed a program for its dual eligibles that incorporates Medicare risk plans. Oregon's program provides Medicaid coverage designed to complement dually eligible beneficiaries' choices of Medicare coverage, with many having the option to enroll in a single prepaid plan that participates in both Medicare and Medicaid.

Other issues that states face regarding dual eligibles can be divided into two categories. Some relate to long-term care, particularly the coordination of payment for such care with acute care. Others, notably concerning continuity of care, relate to disabled dually eligible beneficiaries.

**Long-Term Care Issues.** Long-term care, a large and growing portion of states' Medicaid budgets, is also a dual eligibility issue in two ways. First, as states wrestle with how best to finance and deliver long-term care, the fact that many of those for whom states finance this care are elderly, dually eligible beneficiaries further complicates the problem. Medicare finances most acute care services for Medicaid beneficiaries who are nursing home residents, making it necessary for Medicaid to coordinate this financing with its own payments for long-term care.

Second, state Medicaid programs have limited ability to initiate care-management programs that could help dually eligible beneficiaries avoid the need for nursing home care. This constraint is because Medicare is the primary insurer for dual eligibles and because there is little opportunity for coordinating payment or administration of the two programs. Minnesota's demonstration project addresses this problem by requiring health plans to accept risk for the first 180 days of nursing home care provided to dually eligible enrollees who were not institutionalized when they enrolled.

Two types of demonstrations, financed through both Medicare and Medicaid, have been instituted to address beneficiaries' long-term care needs. The Program of All-Inclusive Care for the Elderly (PACE) was created to provide a comprehensive range of acute and long-term care services (including adult day health care) to elderly Medicare beneficiaries who meet nursing home admission criteria. A primary goal is to keep them living in the community while making care less fragmented and more efficient. PACE sites receive capitation payments from both Medicare and Medicaid. The Social Health Maintenance Organization demonstrations were designed to test whether investing in

---

<sup>25</sup> HCFA's position may also have been influenced by recent judicial decisions requiring states to pay full Medicare cost sharing for QMBs. Some states had paid providers less where their Medicaid fee schedule amounts were lower than the Medicare payment.



some additional benefits for Medicare enrollees could save money by preventing the need for institutional care. Most funding for these demonstrations comes from Medicare capitation payments, although a small portion comes from beneficiary premiums and Medicaid.

**Issues Regarding Disabled Beneficiaries.** How best to finance and deliver care for the high-cost, highly diverse group of disabled Medicaid beneficiaries is also an issue complicated by dual eligibility factors. Traditional managed-care plans that have focused on preventive care may not be as experienced in meeting the various needs of the disabled for specialty care or for chronic physical and mental health care. As states begin to explore innovative approaches for serving these beneficiaries, they must account for the significant proportion of disabled Medicaid beneficiaries who are dually eligible, and the disabled Medicaid beneficiaries who become Medicare beneficiaries upon completing their two-year waiting period. These coordination and continuity issues are likely to affect both plan and beneficiary participation.

### **Issues for Medicare**

Although Medicare is the primary insurer for dually eligible beneficiaries, the special status of this group poses problems for the Medicare program as well as for the states. In addition, as the Medicare program seeks new ways to manage costs and care in its fee-for-service sector, coordination of care-management and financing approaches between Medicare and Medicaid may be further complicated.

Medicare seeks to ensure that dual eligibility facilitates, rather than restricts, access for Medicare beneficiaries. That means that HCFA may increasingly be faced with trade-offs between preserving those protections traditionally afforded Medicare beneficiaries and fostering innovative arrangements to improve care for dual eligibles. At issue is the value of the so-called 50-50 rule for enrollment of the publicly insured in health plans participating in Medicare.<sup>26</sup> Whatever limitation that places on the ability of dually eligible beneficiaries to obtain coordinated care needs to be weighed against the consumer protection provided by this provision.

Finally, state Medicaid programs' use of prepaid health care arrangements for dually eligible beneficiaries may give providers incentives to substitute fee-for-service care covered by Medicare for care covered by Medicaid. For example, Medicaid plans that receive capitated payments to cover acute episodes of home health care could have incentives to hospitalize beneficiaries unnecessarily because of Medicare coverage for inpatient services.

---

<sup>26</sup> The Commission recommends eliminating the 50-50 rule concurrent with Medicare's implementation of an enhanced quality assurance program that incorporates quality and health plan performance measurement. See Chapter 7 for additional discussion of the rationale for this recommendation.



## POLICY DIRECTIONS

The future of caring for dually eligible beneficiaries will in all likelihood be determined by the success of initiatives at the federal and state levels. Coordinated efforts stand the best chance of improving the delivery of health care to this vulnerable group of elderly and disabled beneficiaries.

States are moving forward with demonstration projects authorized by Medicaid waivers. To aid in this effort, a technical advisory group convened by HCFA recently worked with the Center for Vulnerable Populations to develop a guidebook to assist states in contracting with managed-care entities to serve dually eligible beneficiaries (Medicaid Managed Care Technical Advisory Group 1996). The document, designed to be used in planning and implementing state programs, addresses approaches for quality assurance, access standards, marketing, and enrollment, as well as the provision of long-term care, mental health care, and substance abuse services. It also describes ways in which states can coordinate their efforts with Medicare. In developing its framework, the group drew on the experience of states that have used different approaches to serving this population.

In addition to providing guidance, the federal government could take other steps to foster the development of state initiatives in this area. One approach would be to reduce the barriers posed by the current lack of flexibility in Medicare risk-program requirements. Legislative changes to the Medicare risk program with the potential to increase options for serving dual eligibles include altering the 50-50 rule. Other changes likely to benefit dual eligibles would make Medicare and Medicaid risk-program participation standards more comparable, a move now being evaluated by a HCFA work group. In the short term—or to assess the implications of potential changes—legislation broadening HCFA's authority to grant Medicare waivers could also be valuable.

Another approach for developing and testing improved ways to finance and deliver care for this vulnerable population would be to sponsor additional demonstrations that combine federal and state financing. Medicare demonstration projects could yield insight on effective ways of caring for dual eligibles. Medicare restructuring legislation passed by the Congress in 1995 would have authorized demonstration projects to serve chronically ill, dually eligible beneficiaries. Participating plans would have been funded jointly through Medicare and the states. Although the legislation was not enacted, the approach is an attractive one for improving federal and state coordination on behalf of dual eligibles.

## REFERENCES

- Congressional Research Service, *Medicaid Source Book: Background Data and Analysis (1993 Update)*, Committee Print 103-A (Washington, DC: Committee on Energy and Commerce, January 1993).
- General Accounting Office, *Medicaid Managed Care: Serving the Disabled Challenges State Programs*, GAO/HEHS/-96-136 (Washington, DC: July 1996).

Health Care Financing Administration, Department of Health and Human Services, *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996* (Baltimore: October 1996).

Medicaid Managed Care Technical Advisory Group, *A Framework for the Development of Managed Care Contracting Specifications for Dually Eligible Adults* (Portland: Center for Vulnerable Populations, November 1996).

National Academy for State Health Policy, *Medicaid Managed Care: A Guide for States, 3rd Edition* (Portland: January 1997).

Nelson, Lyle, Marsha Gold, Randall Brown, et al., *Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, Selected External Research Series No. 7 (Washington, DC: Physician Payment Review Commission, November 1996).

Office of Inspector General, Department of Health and Human Services, *Medicaid Special Status Classifications Submitted by Medicare Health Maintenance Organizations*, No. A-04-96-01119 (Washington, DC: November 1996).

# Medicaid: Spending Trends and the Move to Managed Care

**M**edicaid is an entitlement program providing payment for medical services to as many as 37 million low-income people who are aged, blind, disabled, or members of families with dependent children. It has three distinct features: joint federal-state financing, state administration in accordance with broad federal standards, and eligibility tied to standards for other cash benefits. Thus, although general eligibility and coverage standards are set at the federal level, each state designs and administers its own Medicaid program. As a result, state programs vary considerably in eligibility requirements, service coverage, utilization limits, provider payment policies, and use of managed care.

During the 104th Congress, both the Congress and the Administration proposed changes to the Medicaid program to limit growth in spending and permit more state innovation in service delivery and payment. Their proposals represented two general approaches to restructuring the Medicaid program: block grants and limits on per capita expenditures. Although both proposals provided more flexibility to states in running the Medicaid program, there were major differences. The congressional proposal would have made more substantial changes and deeper cuts than the Administration's, which retained more aspects of the current program. A later proposal made by the National Governors' Association adopted elements from both approaches. Although various versions of Medicaid legislation were passed by one or both houses of the Congress, no proposal became law. The enactment of welfare reform, however, does affect the Medicaid program. Because Medicaid eligibility historically has been linked to welfare eligibility, federal and state changes in welfare law may affect access to Medicaid benefits.

*This chapter includes:*

- *The financing and structure of the Medicaid program*
- *Medicaid spending trends*
- *Analysis of Medicaid managed-care enrollment*
- *Lessons from implementation of managed-care programs*



This chapter presents background information for understanding the policy debate that is likely to occur in the 105th Congress. It begins with an overview of the Medicaid program, including a brief review of the impact of welfare reform on the program. It presents trends in Medicaid spending, updating previous Physician Payment Review Commission reports that summarized spending by enrollment group, type of service, and state. This section also looks at evidence of a slowdown in Medicaid spending since 1992 and lower projections for future spending than those that drove policy debates in the last Congress.

The next section of the chapter focuses on Medicaid managed care. It first reviews state options for managed care, the waivers of federal rules that are needed to establish different programs, and the types of arrangements that states use. An analysis of how many beneficiaries are enrolled in managed care and how much of overall program spending goes to managed-care plans is then presented. This analysis is more difficult than it appears because of certain inconsistencies in the way beneficiaries and dollars are counted in Medicaid program data and in the different ways managed care is defined. Included in this analysis is the distribution of managed-care enrollment by state and by type of plan.

Finally, the chapter looks at the implementation of Medicaid managed care. The purpose of this section is to see what lessons can be learned from the experiences of the states—lessons that could be helpful to other Medicaid programs or to policymakers considering Medicare changes. Specific areas considered include restrictions on plan marketing, use of enrollment brokers, provision of information to beneficiaries, use of competitive bidding to select plans, and capitation payments to plans. This section concludes with suggestions for further research.

## **MEDICAID PROGRAM FEATURES AND EXPENDITURES**

Much of the impetus for change in the Medicaid program has focused on rising federal and state expenditures. Although the rapid spending growth of the late 1980s has abated somewhat, spending is still projected to grow more quickly than the overall economy.

### **Financing**

Medicaid is jointly funded by the states and the federal government.<sup>1</sup> The federal share of expenditures is determined by a formula based on state per capita income, under which states with relatively low per capita incomes receive higher federal matching rates. For example, Mississippi, with a per capita income that is less than 70 percent of the national average, had a matching rate of about 79 percent, while Connecticut, with a per capita income that is nearly 135 percent of the national average, received

---

<sup>1</sup> In addition to cited sources, the *Medicaid Source Book* was consulted for general information on the Medicaid program (CRS 1993).

a 50 percent match.<sup>2</sup> Since 1987, this matching rate has been recalculated annually. Overall, federal funds accounted for about 57 percent of total Medicaid spending in 1995.

Federal payments to the states are provided from general revenues to match expenditures submitted by the states. There is no limit on the total amount of federal payments. States may finance their share entirely from state funds or require local governments to finance up to 60 percent of program costs. Only a few states have exercised the latter option, with local sources accounting for a small proportion of state financing in most of these states.

## **Eligibility**

Overall, Medicaid helps to finance health care for one of every eight Americans and about one-half of all Americans living in poverty. There is, however, no uniform national basis for establishing Medicaid eligibility. Within the limits of various federal rules, states may choose different eligibility criteria.

In general, beneficiaries can be grouped in three categories: adults and children in low-income families, blind and disabled individuals, and the elderly.<sup>3</sup> Within each category, people may qualify for coverage because they are either categorically or medically needy.

Under federal law, all people meeting 1996 standards for Aid to Families with Dependent Children (AFDC) and most on Supplemental Security Income (SSI) are considered categorically needy and are covered in all states. Starting in the mid-1980s, the Congress expanded Medicaid eligibility to include some persons who do not receive AFDC or SSI cash payments. For the most part, different income standards apply to each of three newly eligible groups: pregnant women and infants, children below the age of six, and children six and older. States have considerable flexibility in setting age and income thresholds (Liska et al. 1996). As a result of these expansions, the proportion of Medicaid beneficiaries who also receive cash welfare benefits declined from about two-thirds in 1990 to just over half in 1995 (CRS 1996).

States also may give Medicaid eligibility to the medically needy, those individuals whose income or resources exceed standards for cash assistance but who meet a separate state-determined income standard and are also aged, disabled, or a member of a family with dependent children. Persons who “spend down” income and assets due to large health expenses may qualify as medically needy. In 1996, 34 states extended eligibility to the medically needy (Liska et al. 1996).

**Gap Between Eligibility and Enrollment.** Some people who are eligible for Medicaid benefits do not sign up. According to the General Accounting Office (GAO), an estimated 3 million of the 14 million children who were eligible for Medicaid in 1994, based on federal standards for age and family income,

---

<sup>2</sup> The federal match for Medicaid services is legislatively set at a minimum of 50 percent and maximum of 83 percent.

<sup>3</sup> See Chapter 19 for a discussion of issues for beneficiaries dually eligible for Medicaid and Medicare.

were not enrolled in Medicaid or covered by private insurance. These Medicaid-eligible uninsured children accounted for 30 percent of all uninsured children in 1994 (GAO 1996a).

GAO indicates several reasons why a gap exists between eligibility and enrollment. First, some low-income families may not be aware that children can be eligible for Medicaid when a parent works full time or when two parents are present. Second, the enrollment process is difficult for low-income families. Some applicants never complete the process, and others are denied eligibility for procedural reasons that are correctable. In other cases, families may regard Medicaid as a welfare program and avoid enrollment unless faced with a medical crisis.

Some states operate outreach programs to get more children enrolled. States, however, face conflicting incentives. Although states seek to improve the health of their residents, expanded enrollment adds to the cost pressures that Medicaid places on state budgets. This is likely to be true even though new Medicaid spending may offset other state expenditures that directly or indirectly finance care for the medically indigent.

**The Effect of Welfare Reform.** Under federal welfare reform legislation (P.L. 104-193), states have the ability to unlink Medicaid eligibility from their new public assistance programs—while keeping a link to old AFDC eligibility standards. About 1.3 million children and more than 4 million parents receive Medicaid based solely on their eligibility for AFDC. Although the law eliminates the AFDC program and replaces it with a new block grant program called Temporary Assistance for Needy Families (TANF), those who were previously eligible for AFDC are supposed to retain Medicaid eligibility automatically. The new law permanently carries old AFDC rules and standards into the Medicaid program, rather than just grandfathering current beneficiaries' eligibility status. States are permitted to modify or simplify Medicaid eligibility standards as long as the 1996 Medicaid rules are treated as minimum standards. As a result of these changes, some individuals will now be eligible for Medicaid even though they are not eligible for TANF (HCFA 1996c; Center on Budget and Policy Priorities 1996; NHPF 1997).

By contrast, two other provisions of the new law may cause some people to lose Medicaid eligibility. First, tightened eligibility criteria for coverage of disabled children under SSI could lead some to lose Medicaid coverage. Some of these children, however, might qualify for Medicaid through other criteria (HCFA 1996b). Second, states will not receive federal matching funds for coverage provided to legal immigrants within five years of their entering the country. Legal immigrants already on Medicaid, however, will not lose their eligibility (HCFA 1996d).

Although the law makes only minor explicit changes in the Medicaid program, some analysts believe there may be greater indirect effects, ultimately reducing the numbers of people receiving Medicaid benefits. Even more than at present, some who qualify may not be enrolled because they do not understand that they are eligible or how to enroll. In addition, states will be faced with decisions on how simple to make Medicaid applications for those eligible for TANF and how aggressive to be in identifying people eligible for Medicaid but not for TANF (NHPF 1997).



If enrollment of eligible individuals does drop, one result may be that some of the poor may delay seeking Medicaid coverage until confronted with an acute episode, especially a costly inpatient stay. This situation is especially problematic if it means these individuals also defer preventive care because they lack coverage. Medicaid managed-care plans could be affected as well if delayed enrollment into Medicaid causes the mix of beneficiaries to be more expensive. States may base capitation rates on the lower utilization levels of the previous enrolled population. If so, plans drawing an average mix of enrollees would be more expensive than the healthier population on which capitation payments are based (United Hospital Fund 1996a; NHPF 1997).

As noted above, there is already a gap between eligibility and enrollment. The Commission last year reiterated its longstanding call for monitoring access in the Medicaid program (PPRC 1996). That recommendation called for the Department of Health and Human Services to monitor access and to report to the Congress on a yearly basis. As part of its recommendation, the Commission called for continued development of a uniform Medicaid claims and encounter data system, a requirement that states participate in that system, and development and administration of a periodic access survey of Medicaid beneficiaries and other low-income persons. The enactment of welfare reform heightens the urgency of monitoring access to health care and reemphasizes the need to determine whether there is an increase of eligible, but not enrolled, beneficiaries.

### **Spending by Enrollment Group**

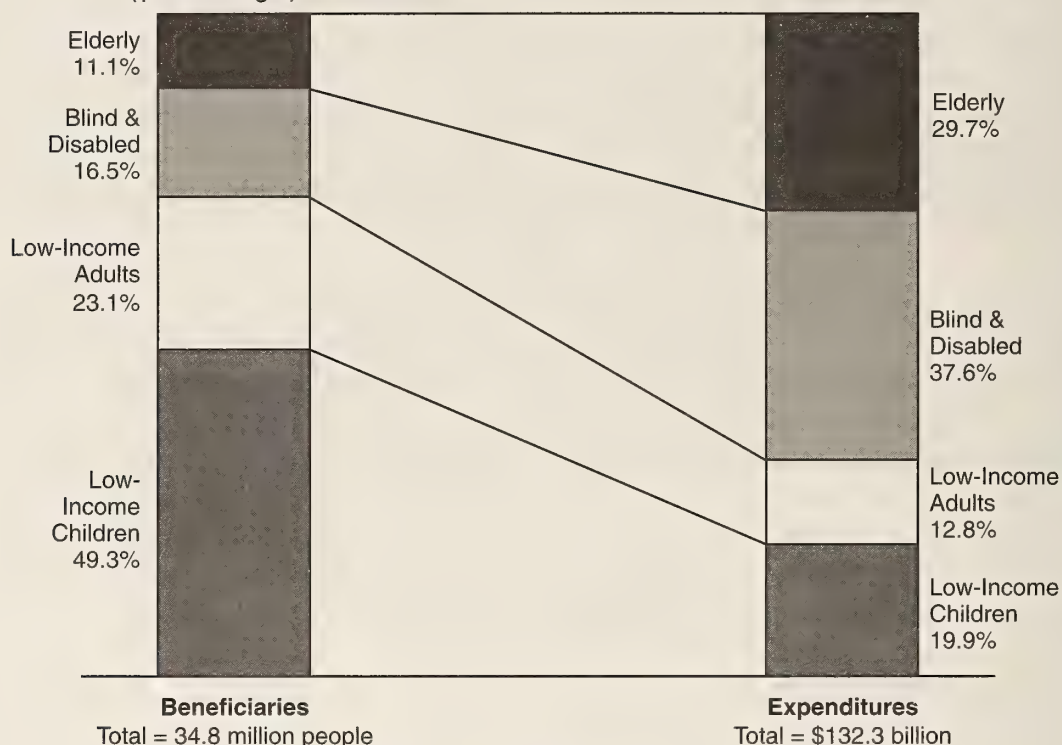
Patterns of service use and overall expenditures differ dramatically among the three major populations served by Medicaid (Figure 20-1). Children and adults in families with dependent children accounted for 72 percent of Medicaid beneficiaries in 1995, but only 33 percent of program payments.<sup>4</sup> By contrast, the elderly, only 11 percent of beneficiaries, accounted for 30 percent of total spending. Blind and disabled persons constituted 17 percent of beneficiaries and 38 percent of payments (Kaiser Commission 1996c; 1997a).

Viewed another way, Medicaid expenditures for each elderly beneficiary in 1995 were almost seven times those for each child and almost five times those for every adult in a low-income family (Figure 20-2). This difference is attributable largely, but not exclusively, to spending for long-term care for the elderly population; levels of acute spending are much more similar among these groups. Spending on blind and disabled beneficiaries is somewhat lower than that for elderly beneficiaries and includes a larger amount of acute care services than the other groups.

---

<sup>4</sup> This analysis excludes administrative expenses and payments to disproportionate share hospitals, which cannot be allocated by enrollment group.

**Figure 20-1. Medicaid Beneficiaries and Expenditures, by Enrollment Group, 1995**  
(percentage)



SOURCE: Kaiser Commission on the Future of Medicaid 1997a.

NOTE: Total expenditures exclude administrative expenses and disproportionate share hospital payments.

### Spending by Service

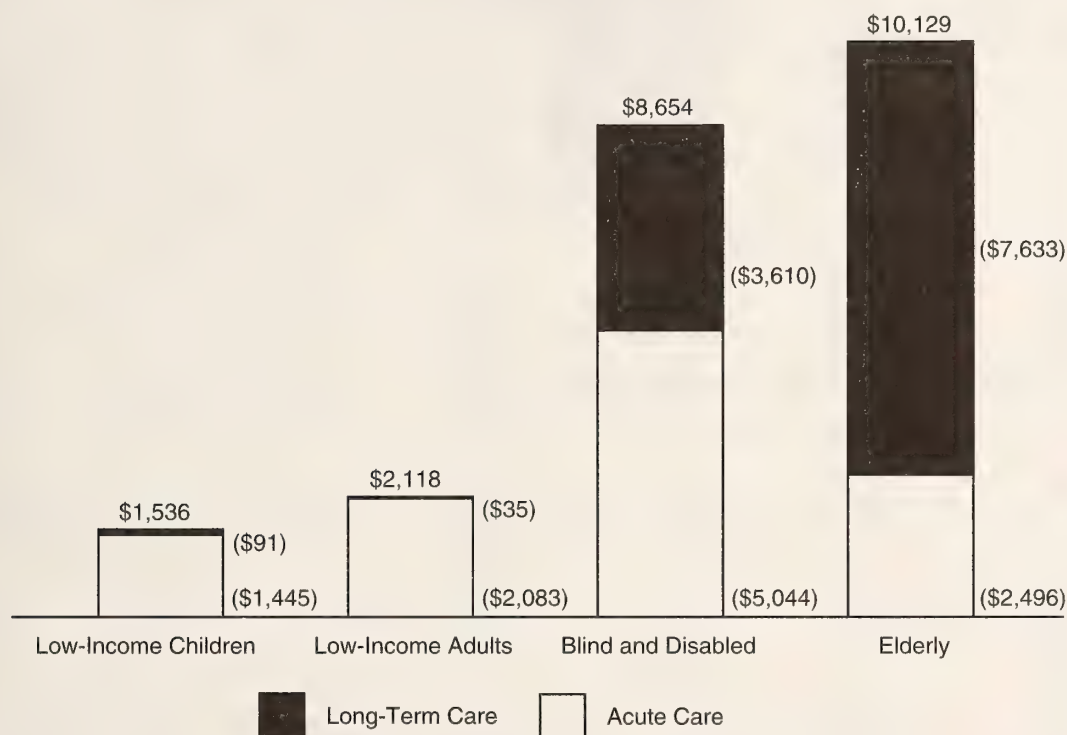
Medicaid requires all states to provide categorically needy beneficiaries a standard benefit package that includes inpatient and outpatient hospital services; physician services; laboratory and X-ray services; family planning; skilled nursing facility (SNF) services for adults; home health care for persons entitled to SNF services; rural health clinic services; nurse-midwife services; and early and periodic screening, diagnosis, and treatment (EPSDT) for children.

The required benefit package for the medically needy is less comprehensive. States opting to cover the medically needy must, at a minimum, furnish ambulatory care for children and prenatal care and delivery services for pregnant women. Almost all states that have medically needy programs, however, provide the same services to both medically and categorically needy beneficiaries.

States may also provide (and receive federal matching payments for) other services, including prescription drugs; dental care; eyeglasses; services provided by optometrists, podiatrists, and chiropractors; intermediate care facility (ICF) services; and ICF services for the mentally retarded (ICF/MR). States vary considerably in the optional services they offer. Virtually all cover prescription

drugs, ICF services, and optometrists' services. States must offer services uniformly throughout the state, providing comparable coverage to all categorically needy beneficiaries and allowing beneficiaries to obtain services from any qualified provider.

**Figure 20-2. Medicaid Expenditures per Beneficiary, 1995 (dollars)**



SOURCE: Kaiser Commission on the Future of Medicaid 1997b.

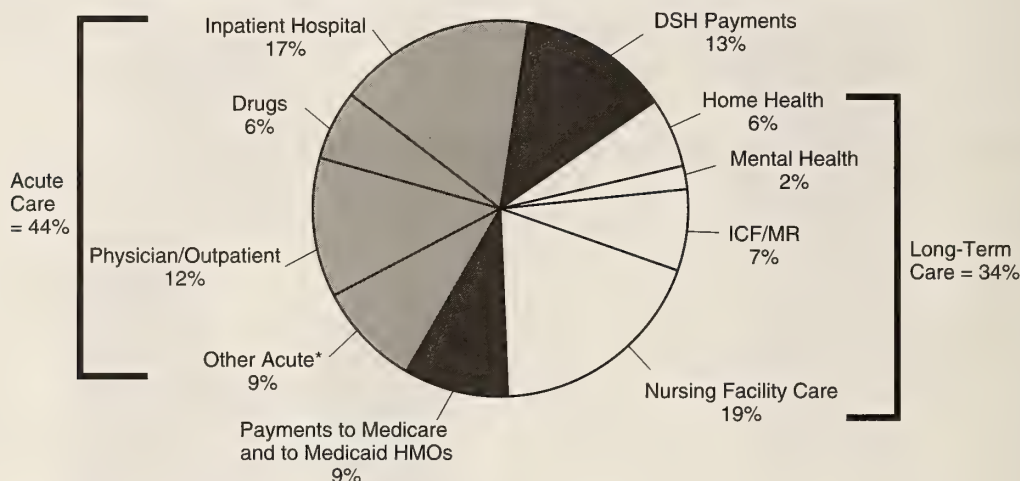
NOTE: Expenditures exclude disproportionate share hospital payments, adjustments, and administrative costs.

Several federal requirements establish Medicaid coverage for poor Medicare beneficiaries. Under these arrangements, beneficiaries typically receive help meeting Medicare cost sharing and may also be eligible for other benefits not covered by Medicare. Chapter 19 of this report provides a detailed examination of dually eligible beneficiaries.

It is not surprising, given the types of beneficiaries eligible for the program, that Medicaid spends large proportions of its budget on both acute and long-term care services (Figure 20-3). Overall, nursing facility care (for both mentally retarded and other beneficiaries) and inpatient hospital services accounted for the largest shares of Medicaid payments, about 26 percent and 17 percent of payments, respectively, in 1995 (Kaiser Commission 1996c; 1997a). Medicaid spends over one-third of its funds on long-term care services, a much higher share than for Medicare or national health spending as a



**Figure 20-3. Medicaid Expenditures by Type of Service, 1995 (percentage)**



SOURCE: Kaiser Commission on the Future of Medicaid 1997a.

\* Includes case management, family planning, dental, EPSDT, vision, and other acute services.

NOTE: Total spending for 1995 was \$151.8 billion.

whole.<sup>5</sup> In fact, Medicaid in 1994 funded almost half of all nursing home care in the United States (Levit et al. 1996).

### Spending by State

Medicaid spending differs dramatically by state (Table 20-1). In 1994, the average annual payment per recipient of Medicaid services ranged from \$2,261 in Tennessee and \$2,529 in Mississippi to \$10,036 in New Hampshire.<sup>6</sup> Because of the wide variation in states' proportions of their low-income populations participating in Medicaid, average spending per poor person ranged from \$969 in Oklahoma to \$4,874 in Connecticut. Finally, on a per capita basis, the highest spending occurs in New York (\$1,164) and the District of Columbia (\$1,350), the result of both high per beneficiary spending and large eligible populations (Liska et al. 1996).

While total state spending is a function of the actual number of Medicaid beneficiaries, differences in service coverage and payment policies also create spending differences across states. The pattern of Medicaid spending among service categories also varies by state. One state may put more money into long-term care, for example, while another state may emphasize inpatient hospital services.

<sup>5</sup> The proportion of Medicaid dollars spent on long-term care services has fallen, however, from nearly one-half in 1988 to about one-third in 1995 (Liska et al. 1996).

<sup>6</sup> New Hampshire's spending is about one-third higher than the next highest state (\$7,311 in New York). The difference is New Hampshire's \$4,596 per beneficiary in disproportionate share hospital payments. Its use of these payments is almost triple the next highest state (Liska et al. 1996).

**Table 20-1. Medicaid Expenditures by State, 1994 (dollars)**

	Total (millions)	Expenditures per		
		Capita	Poor Person	Medicaid Beneficiary
United States	\$137,112	\$ 523	\$2,041	\$4,011
Alabama	1,769	420	1,300	3,287
Alaska	288	500	2,083	4,181
Arizona	1,571	379	1,382	3,088
Arkansas	1,074	437	1,226	3,185
California	14,065	437	1,476	2,809
Colorado	1,119	306	1,602	3,904
Connecticut	2,424	744	4,874	7,042
Delaware	281	389	1,850	3,773
District of Columbia	790	1,350	3,530	6,214
Florida	5,347	372	1,225	3,096
Georgia	3,274	468	1,787	3,058
Hawaii	458	398	1,789	3,841
Idaho	312	264	1,069	2,833
Illinois	5,286	447	1,942	3,668
Indiana	2,811	483	2,085	4,676
Iowa	1,089	386	1,857	3,609
Kansas	981	390	1,798	3,897
Kentucky	1,867	493	1,579	3,007
Louisiana	4,065	949	2,593	5,368
Maine	932	729	2,689	5,288
Maryland	2,246	451	2,228	5,414
Massachusetts	4,696	779	4,254	6,672
Michigan	4,930	513	2,243	4,154
Minnesota	2,470	562	2,818	5,978
Mississippi	1,330	511	1,324	2,529
Missouri	2,533	483	1,685	3,788
Montana	344	398	1,513	3,627
Nebraska	615	372	1,984	3,867
Nevada	418	274	1,317	4,374
New Hampshire	830	726	4,472	10,036
New Jersey	4,793	598	3,256	6,152
New Mexico	665	400	1,249	2,581
New York	21,223	1,164	4,442	7,311
North Carolina	3,175	463	1,769	3,230
North Dakota	279	443	2,019	4,469
Ohio	5,499	486	2,174	3,676
Oklahoma	1,041	310	969	2,680
Oregon	1,105	354	1,531	2,686
Pennsylvania	6,432	531	2,496	5,123
Rhode Island	787	816	4,066	6,224
South Carolina	1,900	521	1,612	3,932
South Dakota	291	406	1,490	4,063
Tennessee	2,694	519	1,753	2,261
Texas	8,137	437	1,466	3,237
Utah	513	262	1,295	3,268
Vermont	284	479	2,442	3,088
Virginia	1,871	285	1,535	2,917
Washington	2,543	478	2,589	3,805
West Virginia	1,254	692	2,015	3,426
Wisconsin	2,256	445	2,133	4,797
Wyoming	158	323	1,355	3,186

SOURCE: Liska et al. 1996.

NOTES: Expenditures include disproportionate share hospital payments.

Beneficiaries are defined as individuals enrolled in the Medicaid program who actually receive medical services.

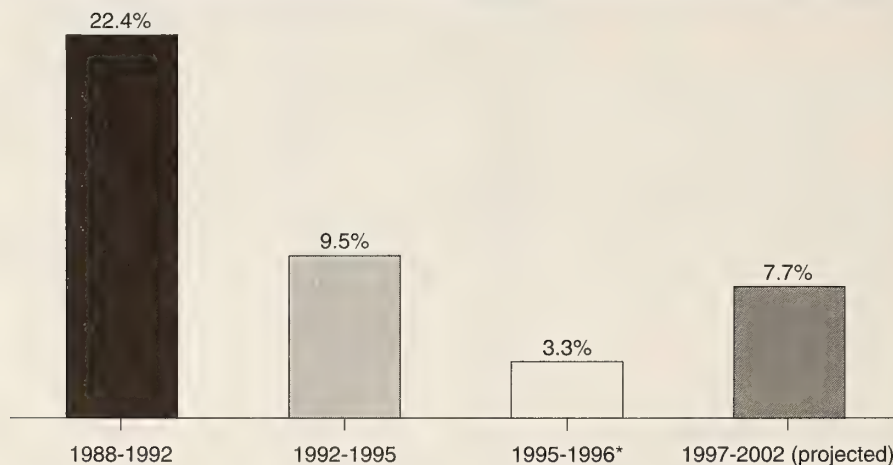
Poor defined as the number of individuals under 150 percent of the federal poverty threshold, which was \$12,320 for a family of three in 1994.

## Trends in Program Spending

In 1966, spending for Medicaid and its predecessor program accounted for \$1.5 billion or 3.7 percent of the nation's personal health care expenditures. By 1994, Medicaid's spending (excluding administration) had increased to \$122.9 billion and its share had climbed to 14.8 percent of personal health care expenditures (Lazenby et al. 1986; Levit et al. 1996). During this same period, the number of Medicaid beneficiaries grew from 12 million to 35 million (Kaiser Commission 1996b).

Medicaid spending growth has been quite volatile over the last decade. Spending went through a period of extremely rapid growth from 1988 to 1992 (Figure 20-4). The average annual growth rate over those years was 22.4 percent. From 1992 to 1995, spending growth declined to 9.5 percent (Holahan and Liska 1996). The current estimate of spending growth for 1996 is 3.3 percent (CBO 1997).

**Figure 20-4. Average Annual Medicaid Expenditure Growth Rate, 1988-2002 (percentage)**



SOURCE: Holahan and Liska 1996; CBO 1997.

\* Based on CBO estimate of spending.

The rapid growth from 1988 to 1992 was driven by three principal factors (Holahan et al. 1993; Holahan and Liska 1996). One was general health care inflation. A second was a significant expansion in enrollment due to both legislative changes and overall economic recession. During the 1980s, the Congress enacted a number of expansions in program eligibility—some mandatory and some optional. States responded by adding almost 8 million people to the Medicaid rolls, a one-third increase, from 1988 to 1992. A third factor was the use by many states of new financing practices, including provider taxes and donations and disproportionate share hospital (DSH) payments.<sup>7</sup>

<sup>7</sup> Disproportionate share hospital expenditures go to hospitals that serve a disproportionate number of low-income patients. States typically encouraged provider contributions or imposed taxes on providers. The state Medicaid program—with matching federal funds—would then increase payment to the hospital enough to return much or all of the donation or tax payment. In some cases, new funds were used to support care for the poor; more often, federal funds were substituted for state funds. DSH payments grew from \$400 million in 1988 to more than \$17 billion in 1992 (Holahan and Liska 1996).



The slowdown in spending after 1992 was equally dramatic and occurred in all categories of enrollees (Holahan and Liska 1996). At least three factors appear to have contributed to this trend. One is the limitation on the use of DSH payments as a result of 1991 federal legislation capping them (as well as restricting the use of other creative financing arrangements). After the rapid growth of earlier years, DSH payments rose by only 2 percent per year between 1992 and 1995.

A second factor was lower growth in spending per beneficiary. Although difficult to demonstrate, this change may be attributable in part to higher enrollment in managed care. Many states consider their managed-care initiatives central to reducing spending growth, but systematic evidence of savings remains unavailable. Managed care cannot be the only factor in moderating spending growth, especially since spending growth actually slowed more rapidly for elderly and disabled populations (who were not in managed care) than for low-income families (who were). General declines in medical price inflation, limits by some states on long-term care spending, and cost shifting to Medicare probably contributed to the slowdown.

A third factor was slower enrollment growth.<sup>8</sup> An improved economy was probably one factor in lowering the number of AFDC enrollees and thus lowering the number of Medicaid beneficiaries. Tightened eligibility requirements as part of state welfare reforms probably also contributed, as did the fact that congressionally driven expansions of eligibility were largely completed. In some cases, slower enrollment growth results from a trade-off made by policymakers—either an implicit or an explicit decision to forgo eligibility expansions in exchange for savings. For example, recent state requests for managed-care waivers have focused more on budget savings than on adding new populations. Similarly, policymakers may be deciding neither to target more age-income groups for eligibility nor to focus on outreach to enroll those who are eligible. As described above, policymakers may face even more difficult trade-offs as a result of welfare reform changes.

### **Projected Increases in Spending**

Projections of spending increases have been a large factor driving legislative initiatives for Medicaid reform. Because new projections are lower than those of a year earlier, the pressure for changes has subsided somewhat. In January 1997, the Congressional Budget Office forecast an average annual rate of Medicaid spending growth of 7.7 percent for the period 1997 to 2002, a significantly lower estimate than those made earlier. In a separate analysis, Urban Institute researchers projected a growth rate of 7.5 percent. One contributing factor to these lower growth estimates is a revised assumption that enrollment growth will be between 1.3 percent and 1.5 percent, roughly half of previous projections. By contrast, enrollment growth was about 7.9 percent from 1988 to 1992 and 5.3 percent from 1992 to 1995 (CBO 1997; Holahan and Liska 1997; Kaiser Commission 1996b).

---

<sup>8</sup> Researchers at the Urban Institute and the Congressional Budget Office show slow enrollment growth (Holahan and Liska 1996; CBO 1997). By contrast, the Health Care Financing Administration's managed-care report shows a slight absolute decline in enrollment (HCFA 1997). As discussed later in the chapter, Medicaid data are often imprecise and unreliable.

## MEDICAID MANAGED CARE

Most Medicaid services traditionally have been provided under fee-for-service arrangements. But the use of managed care has been rapidly expanding. In 1972, Medicaid had contracts with three plans: Health Insurance Plan of Greater New York, Kaiser Permanente in three states, and Group Health Cooperative of Puget Sound. By 1996, over 500 separate entities were serving beneficiaries. Managed care has accelerated in Medicaid during the last few years—from only about 282,000 beneficiaries in HMOs in 1981 to about 13 million beneficiaries in a variety of managed-care arrangements in 1996. After a brief overview of state options for implementing managed-care programs and the different organizational forms of managed care used within Medicaid, this section discusses different ways to measure the growth and penetration of managed care in Medicaid.

### State Options and Waivers for Managed Care

Certain provisions of Medicaid law, such as the requirement that beneficiaries have the freedom to choose their providers, discourage the development of managed care. States may obtain waivers of Medicaid requirements from the Health Care Financing Administration (HCFA) to design programs without these constraints. Different types of Medicaid waivers vary in the amount of flexibility allowed and in the provisions of law to which they apply. The two types of waivers important for managed-care initiatives are program waivers under Section 1915(b) of the Social Security Act and demonstration waivers granted under Section 1115 of the Social Security Act. This section describes each of these.<sup>9</sup>

**Section 1915(b) Program Waivers.** Among other purposes, Section 1915(b) waivers permit states to mandate enrollment in managed care. HCFA can waive certain federal requirements (freedom of choice, uniform statewide operation, and comparability of benefits) to allow states to implement alternative health delivery systems or provider payment arrangements. To receive approval, a state must demonstrate that the program will be cost effective and that access to quality care will not be impaired. These waivers are granted for two years and can be renewed.

As of September 1995, 42 states and the District of Columbia had 1915(b) waivers for managed-care programs (Kaiser Commission 1996a). Michigan, for example, has waivers that allow it to limit Medicaid beneficiaries' choice of providers to primary care case management (PCCM) arrangements and health maintenance organizations (HMOs). Its PCCM program operates statewide, while HMOs are available only in selected counties. This combination is typical of many states.

---

<sup>9</sup> For a more extensive discussion of demonstration waivers, including those used for purposes other than managed care, see Chapter 8 of the Commission's *Annual Report to Congress 1995* (PPRC 1995).

**Section 1115 Demonstration Waivers.** Section 1115(a) of the Social Security Act allows the Secretary of Health and Human Services to approve demonstration projects that will help promote the goals of the Medicaid program. The Secretary has broad discretion in approving these demonstrations and has selectively approved such proposals. These demonstrations are for a limited time, usually three to five years. They generally have not been renewed by the Secretary, but the Congress has extended some legislatively.

The intent of Section 1115 demonstration authority is to test unique and innovative approaches to the delivery and financing of health care. Under a demonstration grant, the Secretary can waive many provisions of Medicaid law.<sup>10</sup> All other sections of the Medicaid law, except those explicitly waived, still apply to demonstrations. Demonstrations require research and evaluation components.<sup>11</sup> Although not a requirement in law, the Administration has a policy of only approving proposals that are budget neutral over the life of the demonstration.

In response to state officials' criticisms of the lack of flexibility in how Medicaid was run, the Administration has expanded use of this waiver authority. States use 1115 waivers to enroll Medicaid beneficiaries in prepaid managed care and to gain flexibility in meeting federal Medicaid program requirements. In addition, some states have sought to use 1115 waivers to expand Medicaid eligibility for acute care services to low-income, uninsured persons; but for the most part, pursuit of this goal has stalled.

As of December 1996, 17 states had been granted Section 1115 waivers. Two states have had their waivers denied. Montana's proposal was denied outright, while Louisiana's was turned down specifically because of the financing mechanism. Eight more states have applications awaiting decisions from HCFA (Kaiser Commission 1996c) (Figure 20-5).

### **Types of Managed-Care Arrangements**

Medicaid managed-care arrangements vary widely in the amount of utilization management involved and the degree to which plans are at risk. HCFA classifies arrangements into four categories: HMOs, prepaid health plans (PHPs), health insuring organizations (HIOs), and PCCM arrangements. For most purposes, however, it is more useful to distinguish between entities at full risk for a comprehensive range of services (generally HMOs, HIOs, and some PHPs); entities at risk for a more limited range of services (some PHPs); and programs that operate on a fee-for-service basis (PCCM arrangements). The analysis presented in the next section makes use of this latter classification.

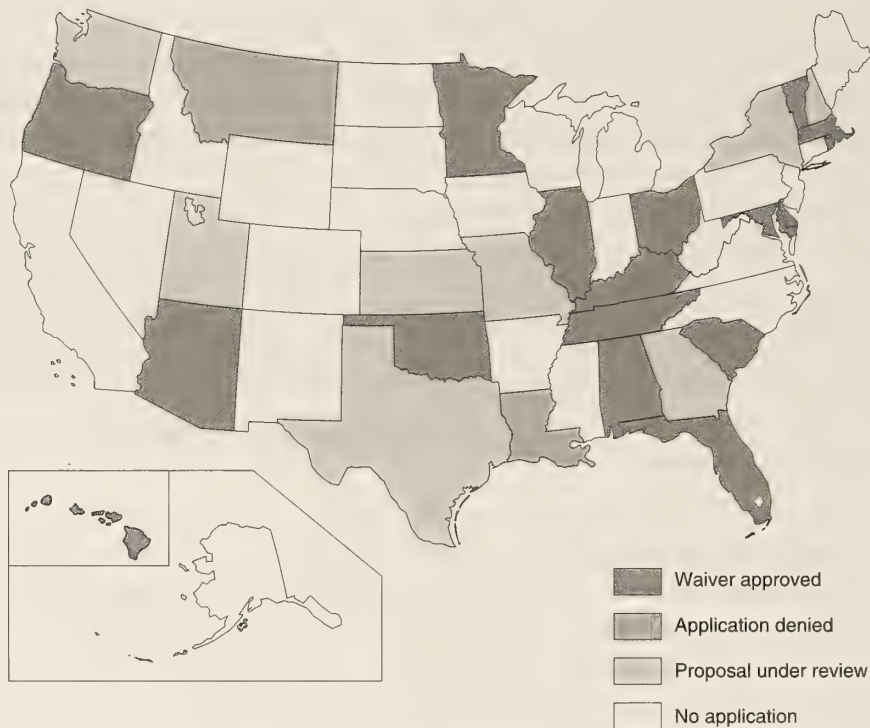
---

<sup>10</sup> One requirement that can be waived is the enrollment composition rule requiring that at least 25 percent of a plan's enrollees be from other than the Medicaid and Medicare programs. The Commission has previously recommended that this rule should be dropped for those states that participate in a quality assurance program (the Health Care Quality Improvement System) (PPRC 1993). See also Chapter 7 for a recommendation on Medicare's enrollment composition rule.

<sup>11</sup> Some evaluation research is under way. Early results from one study have been published (Wooldridge et al. 1997).



**Figure 20-5. Status of Section 1115 State Medicaid Waivers, December 1996**



SOURCE: Liska et al. 1996.

NOTE: Information has been updated to reflect approval of Alabama's waiver.

HMOs provide comprehensive health services to Medicaid beneficiaries in return for a capitated payment that is based on expenditures for comparable beneficiaries in fee-for-service Medicaid. Of the 511 entities participating in some type of Medicaid managed care in 1996, well over half (349) were HMOs.

Prepaid health plans have several variants. They include certain community, migrant, or Appalachian health centers located in medically underserved areas; organizations that contract with the state Medicaid agency for a specific list of services (e.g., behavioral health) or on a nonrisk basis; and comprehensive at-risk organizations that are statutorily exempt from HMO requirements. There were 89 PHPs contracting with Medicaid in 1996.

HIOs pay for services of subcontracting providers and plans and assume all financial risk in exchange for a premium. The HIO organizes a provider network and establishes preauthorization and utilization review to control the volume of services. Network providers serve as case managers and, in some HIOs, receive capitated payments. The extensive use of 1115 waivers has generally eliminated the need to use HIOs, although new ones have been authorized in California. There are only seven HIOs.

Primary care case management arrangements are different from HMOs, PHPs, and HIOs in that they operate on a fee-for service basis and are typically created and run by the states. Under these arrangements, a primary care physician coordinates and approves an array of services in addition to providing primary care services. In most PCCM systems, physicians are paid case-management fees (typically \$3 per beneficiary per month) in addition to their regular fee-for-service payments for the primary care services they provide. In others, physicians are placed at financial risk for some services (usually ambulatory care). Physicians may determine the level of their Medicaid caseloads, up to a state-specified limit. PCCM arrangements operate in 31 states and the District of Columbia; a few states operate multiple programs.

### **Measuring Enrollment and Spending in Medicaid Managed Care**

The Commission estimates that total Medicaid enrollment in all types of managed care in June 1996 was about 12.8 million, or 38.6 percent of all beneficiaries. There has been a steady growth in enrollment, resulting in more than a fourfold increase since 1991. In the last year alone, enrollment grew by one-third from 9.6 million beneficiaries (26.6 percent) in June 1995. Because managed-care enrollees are drawn disproportionately from low-income adults and children, the program's less costly populations, spending on Medicaid managed care represented only about 5 percent of total program spending in 1994. More recent spending data are not available.

Obtaining accurate counts for both enrollment and spending is not a simple task. The Commission's estimates of enrollment for 1995 and 1996 are lower than those published by the Health Care Financing Administration (HCFA 1996a; HCFA 1997). HCFA originally reported enrollment of 11.6 million Medicaid beneficiaries in 1995 and 13.3 million in 1996.<sup>12</sup> The principal reason for the differences between Commission and HCFA estimates is the inclusion or exclusion of different types of managed-care plans or arrangements.

Enrollment in plans that are at full risk for the cost of Medicaid services was about 8.8 million in 1996 (26.5 percent of all beneficiaries). These managed-care plans (generally all plans except PCCM arrangements) are more like those typically found in Medicare and the private sector. Growth in these types of plans has also been rapid—up 44 percent in one year.

Use of managed care by states varies considerably across the country. In five states (and Puerto Rico), more than three of four beneficiaries are in full-risk managed-care plans. At the same time, over one-third of the states have little or no enrollment, although many of these states run significant PCCM programs.

The following sections describe the Commission's analysis of managed-care enrollment and spending, aimed at deriving more accurate counts at both national and state levels. To some extent, this is an

---

<sup>12</sup> HCFA corrected its 1995 number in its report on 1996 enrollment issued in February 1997. The corrected estimate of 9.8 million is very similar—but not identical—to that derived by the Commission for this report.

exercise in purifying bad data. Although the numbers are important for policymakers who need to evaluate Medicaid trends, it is important to emphasize that better data are needed.<sup>13</sup>

**Counting Enrollees in Managed Care.** The goal of this section is to derive two sets of numbers for national and state level managed-care enrollment corresponding to two different criteria for including plans and arrangements. One is a count of Medicaid beneficiaries who participate in any kind of managed care for a broad range of health services. The second is a count of beneficiaries who enroll in an HMO or other health plan that is at full risk for a comprehensive range of services. In each case, managed-care carve-out arrangements that provide only dental or behavioral health services are excluded.

**Excluding Carve-Out Plans.** HCFA's annual reports on Medicaid managed-care enrollment have overcounted managed-care enrollment in significant ways (HCFA 1996a; 1997). An indicator of the problem was that HCFA's 1995 data showed six states (Colorado, Hawaii, Massachusetts, Oregon, Utah, and Washington) with more than 100 percent of their beneficiaries enrolled in managed care.<sup>14</sup> Calculated enrollment rates varied from 101 percent to 589 percent.

Dental and behavioral health managed-care plans provide substantially less than the full range of Medicaid services. For example, certain plans in 3 states provide only dental services, and plans in 11 states are restricted to behavioral health services (generally mental health and substance abuse).<sup>15</sup> These plans are sometimes referred to as carve-out plans. Some beneficiaries in these states enroll in both a regular managed-care plan and either a behavioral health plan or dental plan—and are thus counted twice. In fact, in some states enrollment in a fee-for service PCCM arrangement may automatically trigger enrollment in a risk-based behavioral health plan. Other beneficiaries may enroll only in these carve-out plans. Nationally, these two types of plans represent about 17 percent of HCFA's 1995 count of Medicaid managed-care enrollees (Table 20-2).<sup>16</sup> About 4 percent are in dental plans, and 13 percent are in behavioral health plans.

---

<sup>13</sup> In 1995, researchers at Lewin-VHI prepared an analysis of Medicaid managed-care enrollment. They collected enrollment numbers directly from state officials and compared them with HCFA's numbers. Their analysis shows that there may be even more inaccuracies than revealed by the Commission's analysis (Lewin-VHI 1995).

<sup>14</sup> A footnote on HCFA's enrollment tables suggested the problem, "Totals include duplicated counts of eligibles enrolled in multiple plans." In Hawaii, HCFA reported an additional data problem. Those enrolled under Hawaii's Section 1115 waiver are counted in the enrollment total, but not in the denominator (total recipients) (HCFA 1996a).

<sup>15</sup> In addition to the dental and behavioral health plans, there are plans in some states that provide only primary care services or an even more limited set of services, such as delivery and postpartum care only or newborn services only. They typically exclude hospital services, although they may require primary care physicians to review hospital admissions. These plans, however, appear not to duplicate coverage with other plans. They are not excluded from the Commission's counts, in part because they are not well-distinguished from some PCCM plans.

<sup>16</sup> Plans are identified, with enrollment counts, by HCFA (1996a). More detailed descriptions are in a report on plans operating under Section 1915(b) waivers (HCFA 1996e).



**Table 20-2. Enrollment in Medicaid Managed Care, by Range of Services Covered, 1995**

Range of Services	Number of Enrollees	Percent of Beneficiaries	Percent of Managed-Care Enrollees
Comprehensive Range of Services	9,640,309	26.6%	83.0%
Behavioral Health Services Only	1,535,780	4.2	13.2
Dental Services Only	443,840	1.2	3.8
Any Managed Care*	11,619,929	32.0	100.0

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996a).

\* As noted by HCFA, this total includes duplicated counts of eligible beneficiaries enrolled in multiple plans.

The Commission has concluded that it is appropriate to eliminate enrollees in these carve-out plans from the managed-care counts. HCFA's solution, as shown in its most recent report, differs in that it attempts to eliminate only those enrollees who are double-counted (i.e., enrolled in both a carve-out plan and another managed-care plan) (HCFA 1997). The Commission's solution excludes carve-out plans that offer substantially less than the full range of Medicaid services. Adjustments have also been made to the 1994 and 1996 totals reported by HCFA using this approach.<sup>17</sup> These adjustments eliminate the double-counting of beneficiaries, reducing enrollment below 100 percent for five of the six states identified above (Table 20-3).

There are also errors in the counts of total beneficiaries, the denominators for these calculations, for several states. HCFA attempted to improve these data in its report on 1996 enrollment, noting that Medicaid population counts were collected by states at the same time the managed-care enrollment numbers were collected instead of using regular state data reports as in previous years.

**An Accurate Count of Enrollment in Any Type of Managed Care.** As previously noted, the Commission estimates that enrollment in any type of Medicaid managed care in 1996 was 12.8 million beneficiaries, accounting for 38.6 percent of all beneficiaries.<sup>18</sup> This estimate is about 500,000 below HCFA's published count. Total Commission-estimated managed-care enrollment in 1995 was 9.6 million. This count is about 2 million below the original count HCFA published and about 150,000

<sup>17</sup> HCFA's treatment of carve-out plans in 1994 was more consistent with the decisions described here. The 1994 data tables showed various plans with zero enrollees (HCFA 1995). Actual enrollments were shown in footnotes, but were not included in the totals. A few behavioral health plans in North Carolina and Washington, however, were not identified this way. Adjustments to the 1994 data are made to the tables reported later in this chapter. National enrollment is reduced by less than 1 percent; enrollment for Washington is reduced from 71 percent to 56 percent; enrollment in North Carolina is reduced from 20 percent to 9 percent.

<sup>18</sup> The National Academy for State Health Policy recently estimated enrollment in any type of managed care as between 12 million and 13 million beneficiaries. This estimate, which was based on decisions about carve-out plans similar to the Commission's, used data from a 1996 survey of the states (Horvath and Kaye 1997).

**Table 20-3. Enrollment in Medicaid Managed Care, with Adjustments for Dental and Behavioral Health Plans, 1995 (percentage)**

State	Percent of Medicaid Beneficiaries Enrolled Before Adjustment	Percent of Medicaid Beneficiaries Enrolled After Adjustment
Hawaii	589%	298%*
Washington	141	58
Oregon	117	71
Colorado	114	47
Utah	102	55
Massachusetts	101	48
Iowa	86	31
North Carolina	30	18
California	23	21

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1996a).

\* Individuals who enrolled in managed-care plans under Hawaii's Section 1115 waiver are counted in enrollment totals, but not in the denominator (total recipients).

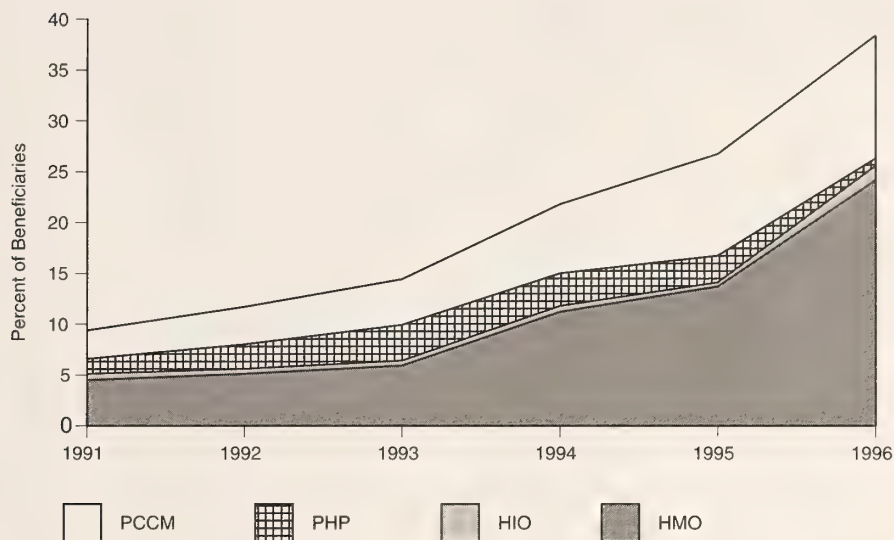
below its corrected figure. Even with these adjustments, the pattern of enrollment over a six-year period shows rapid growth, especially in the last two years (Figure 20-6).

Medicaid managed-care enrollment is concentrated among low-income adults and children.<sup>19</sup> If viewed as a proportion of that population, the managed-care share would be about one-half in 1996. Putting Medicaid's managed-care penetration in context, the share of beneficiaries in managed care is roughly comparable to the proportion of workers in large firms who are enrolled in HMOs. But this share still lags behind the percentage of workers in any type of managed care.

Some 20 states, Puerto Rico, and the District of Columbia have more than 50 percent of beneficiaries in any type of managed-care arrangement (Figure 20-7 and Table 20-4). This figure is more than double the number of states at this level just one year earlier. These states include some (e.g., Arizona and Oregon), where high managed-care penetration characterizes the commercial market and others (e.g., North and South Dakota) that made policy decisions to move aggressively into Medicaid managed care in spite of a low commercial presence. At the other extreme, 8 states (down from 15 in 1995) have fewer than 10 percent of Medicaid beneficiaries in such arrangements. They are mostly small rural states (e.g., Mississippi and Vermont), but also include Texas.

<sup>19</sup> According to data from the National Academy for State Health Policy, just over one million elderly and disabled beneficiaries are in managed care (Horvath and Kaye 1997).

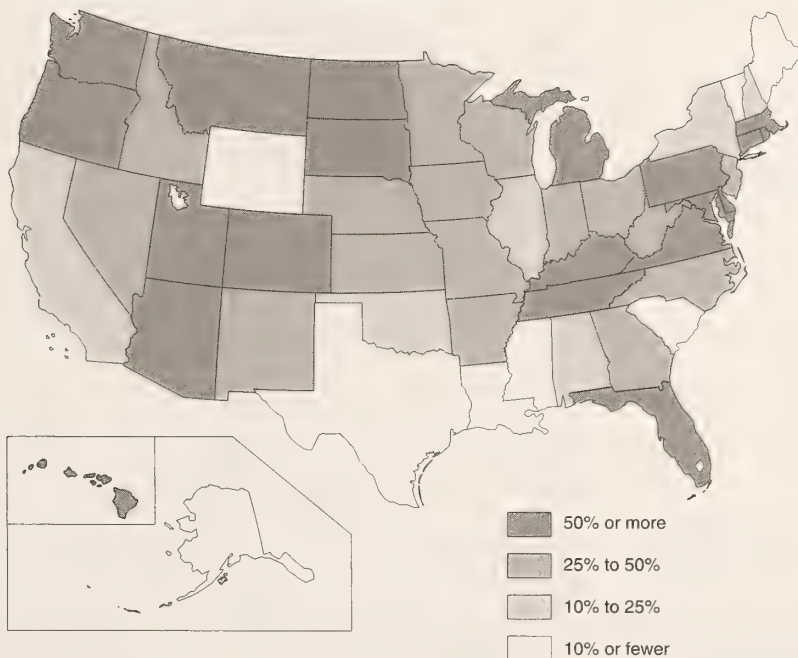
**Figure 20-6. Enrollment Growth in All Types of Medicaid Managed Care, 1991-1996**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1995; 1996a; 1997).

**NOTE:** Enrollment numbers are adjusted to exclude enrollees in dental and behavioral health plans.

**Figure 20-7. Enrollment in Any Type of Medicaid Managed Care, 1996  
(percentage of beneficiaries)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1997).

**NOTE:** Enrollment numbers are adjusted to exclude enrollees in dental and behavioral health plans.



**Table 20-4. Enrollment in Any Medicaid Managed-Care Plans, 1994-1996**  
(percentage of beneficiaries)

State	1994	1995	1996
United States	21.5%	26.6%	38.6%
Alabama	6.8	7.3	11.4
Alaska	0.0	0.0	0.0
Arizona	69.1	68.3	86.1
Arkansas	22.8	38.8	38.6
California	16.3	20.6	23.1
Colorado	47.3	47.0	52.5
Connecticut	0.0	0.0	61.3
Delaware	3.5	8.4	77.6
District of Columbia	33.5	63.2	55.4
Florida	28.5	37.3	63.7
Georgia	0.2	12.2	32.0
Hawaii	4.1	*	80.4
Idaho	2.8	18.8	36.7
Illinois	11.1	9.2	12.9
Indiana	0.0	18.8	31.3
Iowa	15.4	30.5	41.4
Kansas	20.6	40.6	31.7
Kentucky	49.1	44.9	53.1
Louisiana	3.5	5.8	5.6
Maine	0.0	0.2	0.8
Maryland	75.4	77.3	63.5
Massachusetts	67.7	48.4	57.8
Michigan	34.8	64.6	72.7
Minnesota	28.2	29.7	33.2
Mississippi	6.1	6.0	6.9
Missouri	5.6	5.8	34.8
Montana	47.4	43.8	59.4
Nebraska	0.0	0.0	27.5
Nevada	23.8	34.0	40.9
New Hampshire	9.9	11.3	16.4
New Jersey	3.3	11.9	42.8
New Mexico	41.1	43.6	44.5
New York	11.4	19.8	23.5
North Carolina	9.2	17.9	32.3
North Dakota	46.9	46.6	54.6
Ohio	11.8	13.8	32.3
Oklahoma	0.0	0.0	19.4
Oregon	68.7	70.9	80.8
Pennsylvania	32.5	66.1	52.8
Puerto Rico	5.1	5.1	76.3
Rhode Island	1.6	44.7	62.7
South Carolina	2.6	3.2	0.6
South Dakota	4.3	28.1	64.5
Tennessee	90.8	54.8	100.0
Texas	2.6	2.5	3.8
Utah	60.0	54.8	78.0
Vermont	0.0	0.0	0.0
Virginia	30.6	43.2	67.8
Washington	55.9	58.0	60.5
West Virginia	23.5	24.6	30.4
Wisconsin	26.4	30.7	31.8
Wyoming	0.0	0.0	0.6

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1995; 1996a; 1997).

\* Individuals who enrolled in managed-care plans under Hawaii's Section 1115 waiver are counted in enrollment totals, but not in the denominator (total recipients).

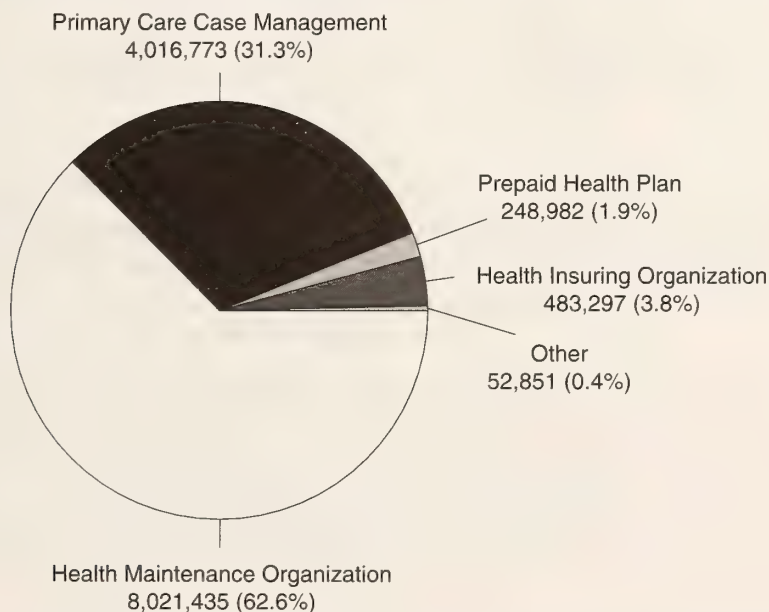
NOTE: Enrollment numbers are adjusted to exclude enrollees in dental and behavioral health plans.

Managed-care growth at the state level is uneven and highly dependent on the timing of waiver approvals and legislative decisions to proceed with new policies. Connecticut, for example, went from no enrollment to about 60 percent between 1995 to 1996. A few states saw modest decreases, but these may be partly a result of data inconsistencies.

**An Accurate Count of Enrollment in Full-Risk Plans.** Although the numbers cited above are accurate as estimates of participation in any type of managed care, they are not comparable to participation in the type of managed care that characterizes the Medicare program or most private-sector HMOs. As noted above, PCCM represents an approach to managing care, but without a transfer of financial risk to private plans or providers. Although physicians are paid a case-management fee, they bear no risk if utilization is high.

Using adjusted numbers, about 63 percent of all Medicaid managed-care enrollees are in HMOs, while about one-third (31 percent) are in PCCM arrangements (Figure 20-8). Only small numbers are in PHPs (2 percent), HIOs (4 percent), and other unclassified managed-care plans (less than 1 percent).<sup>20</sup>

**Figure 20-8. Distribution of Medicaid Managed-Care Enrollment, by Type of Arrangement, 1996 (number and percentage)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1997).

**NOTE:** Enrollment numbers are adjusted to exclude enrollees in dental and behavioral health plans.

<sup>20</sup> Nearly all the excluded enrollees were in PHPs, which had closer to one-fourth of all enrollees in HCFA's reports.

Excluding PCCM participation reduces the enrollment in Medicaid managed care to 8.8 million beneficiaries, 26.5 percent of the Medicaid population.<sup>21</sup> The comparable figure in 1995 was 16.8 percent. Using this definition, Medicaid moved to about double the level of Medicare managed-care enrollment in 1996, after closely mirroring Medicare's enrollment level for the previous several years. Medicaid enrollment in full-risk plans is somewhat lower than the level of commercial enrollment in HMOs only and much lower than the level of enrollment in full-risk plans (see Chapter 1, Figure 1-14).

Like the national totals, state managed-care enrollment levels are affected by the inclusion of PCCM arrangements (Figure 20-9 and Table 20-5). There are 10 states—nearly all rural states in the South or Midwest—where PCCM is essentially the only type of managed care in use. In another 10 states and the District of Columbia, PCCM enrollment represents a substantial proportion of the managed-care involvement. With PCCM excluded, there are 9 states where managed-care enrollment exceeds 50 percent of the state's Medicaid beneficiaries. In 20 states, enrollment is below 10 percent.

**Counting Spending on Managed Care.** Although state Medicaid programs have enrolled a substantial portion of their beneficiaries in managed-care arrangements, the impact on Medicaid spending is far smaller. As noted previously, Medicaid spending is generated disproportionately by the two smaller segments of the beneficiary population: disabled and elderly beneficiaries. Because nearly all of the managed-care enrollment is drawn from children and adults in low-income families, it follows that the proportion of all Medicaid dollars that goes to HMOs is smaller than the proportion of beneficiaries enrolled.

According to 1994 data, HMOs received 5 percent of state and federal Medicaid dollars, while they enrolled 22 percent of beneficiaries that year.<sup>22</sup> Out of the spending on acute care services alone, nearly 10 percent went to HMOs. In only four states (Arizona, Florida, Oregon, and Tennessee) did managed care represent over 10 percent of all Medicaid dollars in 1994.<sup>23</sup>

Although this result is probably a rough indication of managed care's share of program dollars, the details may be somewhat unreliable or at least not fully comparable from state to state. Medicaid program spending data are collected and summarized by individual states and reported to HCFA. Although HCFA performs certain edits to improve consistency and accuracy and Urban Institute researchers have further refined the data, state reports frequently include both errors and inconsistencies.

---

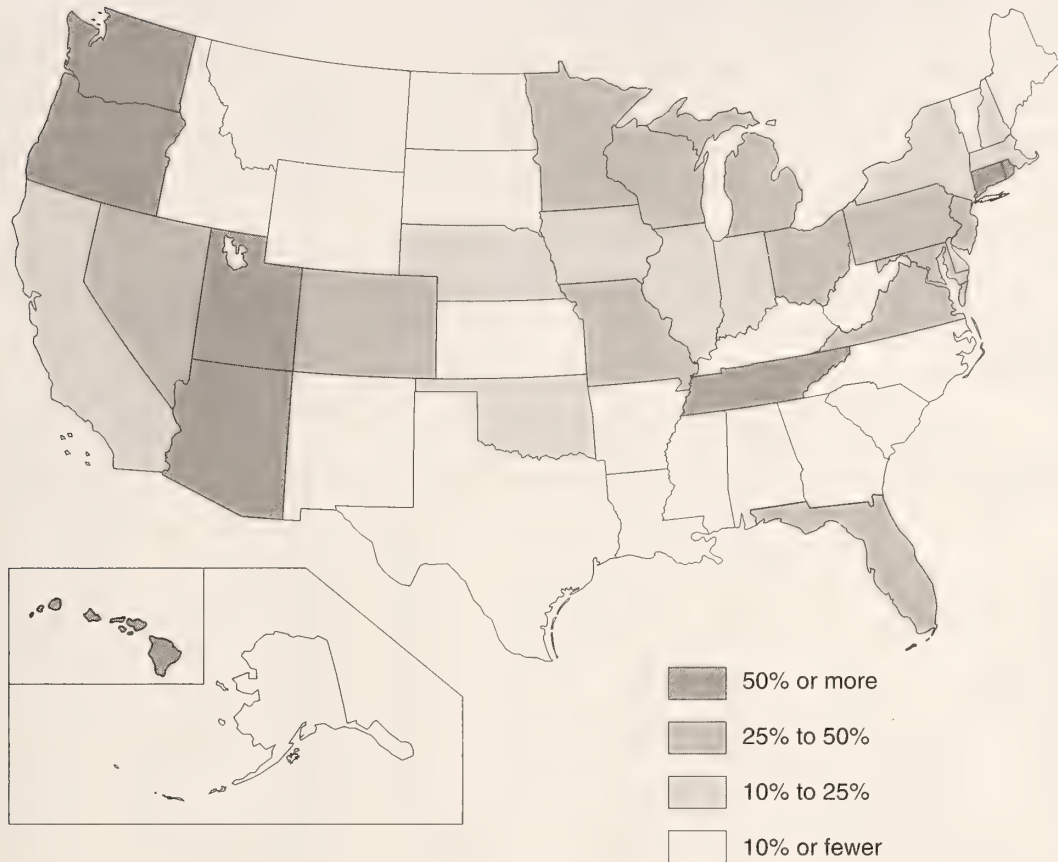
<sup>21</sup> There are about 230,000 enrollees in PHPs, HMOs, or other arrangements that are labeled as partial-risk arrangements in HCFA's database. They represent fewer than 1 percent of all Medicaid beneficiaries. Questions have been raised, however, about the accuracy of HCFA's classification of plans as partial-risk arrangements (Lewin-VHI 1995). To avoid basing adjustments on inaccurate data, these beneficiaries are left in the counts used in this chapter.

<sup>22</sup> The spending data analyzed here come from Urban Institute's analysis of 1994 data states reported to HCFA (Liska et al. 1996). Although HCFA has released more recent data, this analysis takes advantage of certain data cleaning performed by the Urban Institute researchers. As a result, 1994 data are the most recent available data that have been cleaned.

<sup>23</sup> Similar results are found in the analysis of Medicaid spending by Lewin-VHI (1995).



**Figure 20-9. Enrollment in Risk-Based Managed Care, 1996 (percentage of beneficiaries)**



**SOURCE:** Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1997).

**NOTE:** Enrollment numbers are adjusted to enrollees in primary care case management arrangements and in dental and behavioral health plans.

**Table 20-5. Enrollment in Medicaid Risk-Based Managed-Care Plans, 1994-1996**  
(percentage of beneficiaries)

State	1994	1995	1996
United States	14.7%	16.8%	26.5%
Alabama	0.0	0.0	0.0
Alaska	0.0	0.0	0.0
Arizona	69.1	68.3	86.1
Arkansas	0.0	0.0	0.0
California	15.3	19.0	23.1
Colorado	8.0	13.7	27.5
Connecticut	0.0	0.0	61.3
Delaware	3.5	8.4	77.6
District of Columbia	12.6	34.0	30.1
Florida	20.5	24.9	25.4
Georgia	0.0	0.0	0.3
Hawaii	4.1	*	80.4
Idaho	0.0	0.0	0.0
Illinois	7.3	9.2	12.9
Indiana	0.0	6.3	11.8
Iowa	2.7	8.3	12.0
Kansas	0.0	0.0	4.4
Kentucky	0.0	0.0	0.0
Louisiana	0.0	0.0	0.0
Maine	0.0	0.0	0.0
Maryland	24.8	28.9	25.4
Massachusetts	16.6	11.8	13.3
Michigan	20.3	25.1	29.0
Minnesota	28.2	29.7	33.2
Mississippi	0.0	0.0	0.0
Missouri	4.6	4.6	33.7
Montana	0.0	0.0	0.8
Nebraska	0.0	0.0	15.3
Nevada	13.5	26.4	40.9
New Hampshire	9.9	11.3	16.4
New Jersey	3.3	11.9	42.8
New Mexico	0.0	0.0	0.0
New York	11.3	19.7	23.3
North Carolina	0.5	0.5	0.5
North Dakota	0.0	0.0	0.0
Ohio	11.8	13.8	32.3
Oklahoma	0.0	0.0	19.4
Oregon	67.8	68.0	80.8
Pennsylvania	27.8	37.9	32.0
Puerto Rico	5.1	5.1	76.3
Rhode Island	1.6	44.7	62.7
South Carolina	0.0	0.0	0.6
South Dakota	0.0	0.0	0.0
Tennessee	90.8	54.8	100.0
Texas	1.3	1.2	1.4
Utah	13.1	24.7	66.4
Vermont	0.0	0.0	0.0
Virginia	0.0	8.0	38.0
Washington	27.9	56.6	59.5
West Virginia	0.0	0.0	0.0
Wisconsin	26.4	30.7	30.3
Wyoming	0.0	0.0	0.6

SOURCE: Physician Payment Review Commission analysis of Health Care Financing Administration data (HCFA 1995; 1996a; 1997).

\* Individuals who enrolled in managed-care plans under Hawaii's Section 1115 waiver are counted in enrollment totals, but not in the denominator (total recipients).

NOTE: Enrollment numbers are adjusted to exclude primary care case management arrangements and enrollees in dental and behavioral health plans.

The extent of problems in reporting managed-care spending data is suggested by calculations of spending per enrollee (Table 20-6). Among the states with at least 25 percent enrollment in all kinds of managed care in 1994, several spent close to the national average of \$877 per enrollee. But others were well above that amount. Arizona's \$2,515 per enrollee can be explained because Arizona funds its system primarily through capitation payments, including spending for the more expensive elderly and disabled beneficiaries (GAO 1995a). But other differences are harder to explain.<sup>24</sup>

**Table 20-6. Medicaid Spending on Managed Care, for States with over 25 Percent Enrollment, 1994 (dollars)**

State, by Proportion of Managed-Care Enrollment in Primary Care Case Management Arrangements	Spending on HMOs (thousands)	Spending Per Enrollee
United States	\$6,803,637	\$ 877
Over 75 Percent		
Kentucky	36	0
Montana	270	6
New Mexico	0	0
North Dakota	66	2
Virginia	15	0
25 Percent to 75 Percent		
Colorado	34,399	254
District of Columbia	37,661	884
Florida	544,374	1,106
Maryland	206,805	661
Massachusetts	347,622	729
Michigan	401,933	973
Pennsylvania	577,354	1,417
Utah	25,308	269
Less than 25 Percent		
Arizona	884,459	2,515
Minnesota	175,386	1,505
Oregon	164,670	583
Tennessee	896,972	829
Washington	204,556	548
Wisconsin	186,959	1,504

**SOURCE:** Physician Payment Review Commission analysis of data from HCFA (1995) and Liska et al. (1996).

**NOTE:** In calculating spending per enrollee, enrollees in dental and behavioral health plans were excluded.

<sup>24</sup> Two states, not shown in Table 20-6, are particular anomalies. Hawaii's estimated spending of \$8,676 per enrollee probably results from inaccurate counting of managed-care enrollment. Indiana reported \$223 million spent on HMOs but no managed-care enrollees. Indiana did report substantial managed-care enrollment in 1995, so the error could be a discrepancy in the timing of reporting of different types of data.



Several states reported annual spending per enrollee of \$100 or less, including some that showed no spending on HMOs. The vast majority of these states' managed-care programs were organized on the fee-for-service PCCM model in 1994. Apparently they report only the case-management fees paid to physicians as managed-care expenses—if they even report those. Other services are presumably accounted for on a fee-for-service basis.

If all fee-for-service PCCM enrollment is eliminated from the accounting, managed-care spending per enrollee is estimated at about \$1,200, far lower than Medicaid's overall 1994 level of about \$4,000 spending per beneficiary (Table 20-1). But because most managed-care enrollees are not from the higher-spending groups in the program (the elderly or disabled), the average 1994 spending of \$1,550 per beneficiary among low-income adults and children would be a better comparison. The difference between this \$1,550 average and the \$1,200 average for those enrolled in managed care could reflect savings accomplished in managed care. It could also reflect factors such as risk selection or differences in average spending or benefits covered between states with low and high managed-care penetration.

**The Bottom Line on Counting Managed-Care Enrollment and Spending.** The Commission's analysis leads to two conclusions about managed-care enrollment and spending. First, using available data, it is possible to estimate the levels of enrollment in any Medicaid managed care and in full-risk managed-care plans. Very rough estimates of spending in the typical Medicaid managed-care program have also been made. These estimates are important for understanding the dimensions of the role managed care is playing in Medicaid.

More importantly, however, the data are extremely unreliable, so that the estimates reported here are quite approximate. If the role of managed care in Medicaid is to be understood fully, better data should become a priority for the program.

## **IMPLEMENTATION OF MEDICAID MANAGED CARE**

States that have moved actively into Medicaid managed care have made a number of different decisions about how to structure program features such as enrollment and disenrollment, marketing, use of enrollment brokers, selection of plans, and capitation payments to plans. Examination of these decisions is important for at least two reasons. First, as more states opt to move more Medicaid beneficiaries into managed care, they will face a similar set of decisions. It would be helpful if these states could avoid repeating mistakes made by their predecessors.

Second, the Medicaid experience may offer lessons for the Medicare program. If future changes in Medicare should call for a rapid expansion of managed-care enrollment, then the Medicaid experience could be instructive, especially to the extent that both programs have sizeable populations with no managed-care experience. In some cases, the Medicaid experience appears to reinforce previous Commission conclusions about policies for Medicare, for example, that the availability of comparative information on plan options is critical for beneficiaries to make meaningful choices among competing

plans (PPRC 1996). In other areas, the Medicaid experience may offer insight into issues, such as the use of enrollment brokers, where the Medicare program lacks experience.

Studies of state experience in Medicaid managed care by three organizations provide material for this section. The final part of this section describes further work needed to study relevant policy issues more fully.

First, the National Academy for State Health Policy (NASHP) recently published its third survey of state Medicaid programs, conducted in 1996 (Horvath and Kaye 1997). It included separate analyses of risk-based programs (found in 38 states) and PCCM arrangements (32 states). Like earlier surveys, it covers several topics of interest to the Commission. NASHP also completed a study of state enrollment and disenrollment policies in 1996 (Horvath and Kaye 1996).

Second, the Commonwealth Fund and the Henry J. Kaiser Family Foundation funded a series of case studies examining the experiences of five states (California, Minnesota, New York, Oregon, and Tennessee) in implementing managed-care initiatives (Gold et al. 1996).<sup>25</sup> These studies involved site visits to the states in 1994 and 1995 to identify issues and early lessons. Each of the studied states had set a goal of moving at least half of its beneficiaries into managed care—some within a year's time, others over a longer period. Two states were operating under approved Section 1115 waivers; two others had initiatives under way, while awaiting approval of Section 1115 waiver applications. The fifth was operating under a Section 1915(b) waiver.

Finally, the General Accounting Office in 1996 released a report on Medicaid managed care (GAO 1996b). It reviewed documented cases of marketing and enrollment abuses from five states (California, Florida, Maryland, New York, and Tennessee) that had received media attention for their problems. It also studied education and enrollment programs in four states (Minnesota, Missouri, Ohio, and Washington) that were identified by experts as noteworthy for their innovative approaches. In addition, GAO has made several other reports to the Congress on individual state experiences in Medicaid managed care (GAO 1995a; 1995b).

### **Restrictions on Plan Marketing**

States have the option of relying on participating health plans to market their products to beneficiaries. But states may also ban direct plan marketing and take responsibility themselves for informing beneficiaries about their options. The case studies found significant problems resulting from direct plan marketing, leading a number of states to assume the marketing function.

---

<sup>25</sup> Individual case studies have been published for the five states (Gold et al. 1995a; 1995b; Sparer and Chu 1996; Sparer et al. 1996a; 1996b). Site visits, as part of this study, have been made to two additional states, Florida and Texas. The Florida case study is complete and will be released shortly; the Texas case study is in preparation.

For states relying on plans for marketing, HCFA has guidelines that most have adopted. The guidelines require plans to demonstrate that their marketing materials are accurate and that procedures used do not mislead or confuse beneficiaries. Plans appear to prefer direct marketing because it enhances their ability to increase market share. Plans also find that they are able to combine marketing with other tasks, such as orientation of new enrollees. Typically, direct marketing occurs at beneficiaries' homes, in public assistance offices, at community sites like check-cashing locations, or through targeted mass mailings. Plans are permitted to offer gifts (with a value under \$10) as incentives to enroll (GAO 1996b).

According to the 1996 NASHP survey, only 10 states operating risk-contracting programs relied solely on government for outreach and marketing, and only 1 state gave plans sole responsibility. Most shared responsibility in some way (Horvath and Kaye 1997).

The 1996 GAO study cited various reported abuses that have resulted from plans' marketing activities. Examples included misrepresentations by plans' sales agents to beneficiaries, especially about the use of network providers; inappropriate or fraudulent enrollment by sales agents who are paid on commission for each person enrolled; and abuses of gifts used as enrollment incentives. Each of the five states where abuse had been reported took enforcement actions or levied fines against the offending health plans. In addition, four banned or restricted door-to-door marketing by plans. New York, however, temporarily suspended its ban because it led to a decline in enrollment (GAO 1996b).

The four states that GAO identified as examples of innovative programs all prohibited or significantly restricted plans from initiating contact with nonenrolled beneficiaries. These decisions generally came in conjunction with the states' moves to mandatory enrollment. These states either chose to act directly as the principal source of information or to employ enrollment brokers.

GAO concluded from its study that allowing plans to market directly to Medicaid beneficiaries resulted in some abusive practices that states find difficult to prevent. While the agency found that performance measures are needed to determine what approaches to education and enrollment work best, it appeared to prefer that these efforts be organized by the state (directly or through brokers).

Of the five states in the Kaiser/Commonwealth study, two have banned direct plan marketing altogether. The other states have allowed at least some marketing by plans. As in the GAO study, the researchers reported that enrollment and marketing processes functioned much more smoothly where plan marketing was prohibited than elsewhere. The study pointed out that the design and funding of these processes is critical and that problems arise even with good planning. Oregon, for example, initially received 4,000 calls a day—compared with expectations of 5,000 calls per month (Gold et al. 1996).

One concern raised in states where plan marketing was not permitted came from smaller Medicaid-only plans. They thought they were placed at a competitive disadvantage because they could not build name recognition through advertising nominally directed to the commercial market.



There appears to be a clear trend for states to regulate plan marketing tightly or, in many cases, to ban direct plan marketing. This trend has created new interest in finding other ways to inform beneficiaries about their options.

### **Enrollment Brokers**

A growing number of states have chosen to contract out education and enrollment responsibilities to enrollment brokers. GAO reported that, overall, more than half of the states with a mandatory managed-care program use enrollment brokers or are considering contracting with them (GAO 1996b). The 1996 NASHP survey identified 18 states that used a private entity (other than the plans) for marketing their risk-based plans, though not all used them as the sole source of information. Other states use brokers in their PCCM programs (Horvath and Kaye 1997).

Conclusions about the effectiveness of using private enrollment brokers are mixed. Generally, the fact that enrollment counseling is done at all appears to be more important than whether the state contracts the function out to a private entity. NASHP concluded that benefits counseling can be contracted out to a private entity or performed by agency caseworkers, but that the most significant factor is the scope of responsibilities assigned to the benefits counselor (Horvath and Kaye 1995).

One indicator used to evaluate the effectiveness of different enrollment approaches is the extent to which beneficiaries choose their own plan or whether the state (assuming a mandatory enrollment policy) assigns them to one of the available plans. A well-designed enrollment counseling program, concluded NASHP, should help reduce the number of state assignments, boost satisfaction with choices of plan and providers, and lead to greater acceptance of managed care generally (Horvath and Kaye 1995).

The Kaiser/Commonwealth study reached a mixed conclusion about using enrollment brokers. In two of five states, the study reported that the enrollment experience was smooth. Oregon used an enrollment broker, while Minnesota handled the task through the state and counties. By contrast, the study found that in California, where a broker was used in the Sacramento County program, enrollment was characterized by confusion. Because the county preferred running the program itself, the state's decision to award the contract to a private broker was controversial and was finalized only four months before mandatory enrollment was to begin. The resulting process was characterized as chaotic and problematic, with incomplete informational materials, an understaffed toll-free telephone line, and other problems. About 16 percent of beneficiaries signed up for more than one plan. Some of the problems were resolved only after a 90-day delay of the program's start-up, but other problems have persisted (Gold et al. 1996; Sparer et al. 1996b).

GAO reported that using state employees as enrollment counselors can take advantage of in-house knowledge of the Medicaid program and the populations served. At least in the short term, though, it may be hard to add enrollment and education responsibilities to staffers' existing obligations for the fee-for-service program. Enrollment brokers can sometimes develop needed services (including

services for non-English-speaking beneficiaries and toll-free telephone lines) at a lower cost than the state can. Missouri reportedly chose to use a broker because of limits it faced in hiring more state employees and because it could accelerate implementation with this approach. Ohio, on the other hand, chose this approach because of a good experience in Dayton, where use of brokers provided a neutral source of information (GAO 1996b).

### **Availability of Information**

As noted above, beneficiary education and counseling can be critical to the success of managed-care initiatives. Although none of the studies reviewed here had data from beneficiaries to judge how well-informed or satisfied they were with the enrollment process, they agreed on the importance of the information process. Furthermore, they agreed that the content of the information and the process by which it is communicated are critical. The source of information is less vital, provided it is neutral and unbiased.

GAO's report noted that all four states selected for their exemplary programs took responsibility in some way for the task of informing beneficiaries about how best to access care in a managed-care system and how to choose a plan. These tasks are particularly important for a clientele having only limited experience with managed care or its restrictions on provider use (GAO 1996b).

States chose to use in-person meetings and mail or telephone contacts, depending on available resources and how rapidly decisions had to be made. GAO concluded that states seemed to prefer in-person interactions where possible. Whether these sessions occur in small groups or as individual interactions, they give counselors a chance to explain complex materials and choices. States that use mail or telephone contacts may use in-person consultations as a backup. All four states studied also used community-based groups to supplement the state's educational programs. The GAO study did not, however, report in detail on the content or subject matter of informational materials or meetings (GAO 1996b).

The Kaiser/Commonwealth study pointed to similar findings in drawing lessons from the five state experiences. For example, it cited the importance of an enrollment process that includes written materials designed for low-income populations, a toll-free telephone number that can address a large volume of questions, and a means of providing in-person counseling (Gold et al. 1996).

There are many issues related to the content of the information provided. Beyond factual data on plan characteristics that beneficiaries need to make choices, good information about provider networks is also needed. In addition, experts cite the importance of performance data, including the use of Medicaid's edition of the Health Plan Employer Data and Information Set (HEDIS). According to the NASHP survey, 27 states used some version of HEDIS. Only two, however, used reports cards as an educational strategy (Horvath and Kaye 1997). Many of these issues parallel similar issues that the Commission has addressed for the Medicare program (see Chapter 7).

## **Enrollment and Disenrollment Policies**

Medicaid law requires that beneficiaries retain full freedom of choice of providers. As a result, mandatory enrollment in HMOs requires a waiver. Further, Medicaid law generally limits enrollment lock-ins to one month, although a six-month lock-in is allowed for an HMO meeting certain federal requirements. Under a Section 1115 waiver, lock-ins may be extended to 12 months. Where mandatory enrollment is in place, states must also determine whether to establish an annual open enrollment season or to allow continuous enrollment. These policies can become especially complex for Medicaid, where beneficiaries can gain and lose eligibility for benefits multiple times during a year.

A majority of states now have some type of mandatory enrollment policies, although details vary considerably. According to the NASHP survey, 31 of 38 states with risk-based programs have mandatory enrollment. Those not choosing a plan are assigned one. Most states with PCCM programs also have mandatory enrollment. Apparently, most states have maintained the monthly right to disenroll. Nine states, however, reported using a six-month lock-in, and five (all Section 1115 waiver states) set a 12-month lock-in period (Horvath and Kaye 1997).

NASHP, however, found no connection between different enrollment policies and rates of disenrollment or auto-assignment. It also found little use of disenrollment data as a program management tool (Horvath and Kaye 1996). None of the studies, however, drew conclusions about the broader effects of extending lock-ins beyond requirements in current law.

## **Competitive Selection of Plans**

The use of competitive bidding to select plans for participation in managed-care programs is a significant trend in Medicaid, with eight states now using it in some way (Horvath and Kaye 1997). Arizona has used this approach for more than a decade, and it has been credited with helping to keep costs down (GAO 1995a). In several other states, the use of competitive bidding is much more recent. It is probably too early, therefore, to draw any conclusions. Competitive bidding is thus an ideal candidate for further research.

In 1994, Arizona sought bids for three-year contracts with plans. The state described its general requirements in a request for proposals and received 95 bids for 42 contracts it was making available in 15 counties. Arizona had previously developed capitation rate ranges based on historical utilization data. These ranges, not shared with the bidders, were used to evaluate the bids. Low bids received higher scores, but bids that were excessively below the range were considered unacceptable. If an initial bid was above the range, the bidder was allowed to submit a second bid. Arizona also evaluated a plan's provider network, its management, and its past experience. Ultimately, the 42 contracts were awarded to 14 plans (GAO 1995a).

California is implementing a new system for selecting plans in 12 of its largest counties. In each case, two plans are permitted to enroll beneficiaries. One is called a local initiative plan and is normally



formed by the county government. This option was designed in part to protect county-based safety net providers. The other, called a mainstream plan, is a private plan selected through a bidding process. Apart from the mechanics of the bidding process, this approach has been criticized by the managed-care industry for unnecessarily limiting competition and beneficiary choice.<sup>26</sup> In some counties, lawsuits have been filed challenging the selection process. Implementation was also delayed until the 1915(b) waiver was approved and because of start-up problems with the local initiative plans. Although mainstream plans were chosen in most counties in 1995, the two-plan model is not yet operational in any county (GAO 1995b; Sparer et al. 1996b).

New York State adopted competitive bidding in 1995. New York City recently awarded contracts to 20 plans, 6 of which were new to the program. Plans that met the state's initial technical and financial criteria were reviewed by city officials before being offered contracts. Although some plans were not approved, the plans whose contracts were renewed accounted for 97 percent of previous enrollment (United Hospital Fund 1996b).

### **Capitation Payments and Risk Adjustment**

According to the NASHP survey, 30 of 38 states with risk-based programs used a rate-setting approach to establish capitation payments (Horvath and Kaye 1997). Many of these are similar to that used in the Medicare program. States tell plans how much they will pay to provide services to plan enrollees. By law, capitation payments to managed-care organizations must be computed on an actuarially sound basis and cannot exceed what would be paid for an equivalent group under fee-for-service Medicaid. The latter requirement has been waived in some demonstration states.

States typically pay a percentage (generally 85 percent to 95 percent) of the cost of serving enrollees under fee-for-service Medicaid.<sup>27</sup> This approach is designed to guarantee a level of savings to the states. As in Medicare, savings may not be realized if risk differences between plan enrollees and other beneficiaries are not accounted for through a risk-adjustment mechanism. In states with mandatory enrollment (at least for certain categories of beneficiaries), risk adjustment is not a problem for guaranteeing savings to the state, although it may be an issue in ensuring fair payment among participating plans.<sup>28</sup>

One issue is whether the methods used provide compensation that is adequate to support access for beneficiaries and to encourage competition among plans. The Kaiser/Commonwealth study found that three of five states set uniform rates for all plans in a given area, while the other two negotiated

---

<sup>26</sup> In some cases, the local initiative plan can contract with a number of private health plans, resulting in more choice for beneficiaries than appears on the surface.

<sup>27</sup> Even more than in Medicare, this calculation is increasingly problematic. As the proportion of beneficiaries in managed care grows, the cost experience of fee-for-service beneficiaries becomes a less stable and less typical basis for calculating capitation rates.

<sup>28</sup> See Chapter 5 of this report for a discussion—mostly in the Medicare context—of the importance of risk adjustment for promoting access to care for vulnerable populations.

individually with plans over rates (within constraints) (Gold et al. 1996). In several states, notably Tennessee, the level of the capitation rates has been a central issue in debates over the program's future. Several managed-care plans withdrew from state programs in 1996, blaming state cuts in payments among other factors (Page 1997).

An additional issue is whether states are making progress in developing and implementing innovative approaches to risk adjustment. The NASHP survey found that a majority of states make risk adjustments for age, sex, geography, and eligibility category. Most states also used some type of risk sharing or reinsurance. Only four reported adjusting rates for health status in 1996 (Horvath and Kaye 1997).

### **Further Research**

States' experiences in implementing their managed-care programs may be instructive both to other states' Medicaid programs and to the Medicare program. With the variety of approaches in use, several natural experiments are under way. Although the studies identified here offer some suggestions about what approaches have been more successful than others, more systematic research on these issues is needed. Some studies are in progress, including ongoing survey work by the National Academy for State Health Policy and projects funded by HCFA and by the Robert Wood Johnson Foundation.

The first stage in a study to examine these issues further would be a survey of states with significant managed-care activity. The survey should cover some of the topics identified in this section. For example, it might ask about restrictions states place on plan marketing, use of enrollment brokers, how information is communicated to beneficiaries, use of competitive bidding to select plans, setting of capitation payments, and risk adjustment. A second stage could explore the success and failure of these different approaches and some of the factors that help determine which succeed and which fail.

### **REFERENCES**

- Center for Budget and Policy Priorities, "An Analysis of the AFDC-Related Medicaid Provisions in the New Welfare Law," unpublished memorandum, September 19, 1996.
- Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1998-2007* (Washington, DC: January 1997).
- Congressional Research Service, *Medicaid Source Book: Background Data and Analysis (A 1993 Update)*, Committee Print 103-A (Washington, DC: Committee on Energy and Commerce, U.S. House of Representatives, January 1993).
- Congressional Research Service, *Medicaid Spending and Enrollment: A State Chart Book*, No. 96-839 EPW (Washington, DC: October 10, 1996).

- General Accounting Office, *Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs*, GAO/HEHS-96-2 (Washington, DC: October 1995a).
- General Accounting Office, *Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan*, GAO/HEHS-95-87 (Washington, DC: April 1995b).
- General Accounting Office, *Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate*, GAO/HEHS96-129 (Washington, DC: June 1996a).
- General Accounting Office, *Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO/HEHS-96-184 (Washington, DC: September 1996b).
- Gold, Marsha, Karyen Chu, and Barbara Lyons, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon* (Menlo Park, CA: Henry J. Kaiser Family Foundation, July 1995a).
- Gold, Marsha, Hilary Frazer, and Cathy Schoen, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee* (Menlo Park, CA: Henry J. Kaiser Family Foundation, July 1995b).
- Gold, Marsha, Michael Sparer, and Karyen Chu, "Medicaid Managed Care: Lessons from Five States," *Health Affairs* 15(3):153-166, Fall 1996.
- Health Care Financing Administration, Department of Health and Human Services, *Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 1994* (Baltimore: 1995).
- Health Care Financing Administration, Department of Health and Human Services, *Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 1995* (Baltimore: 1996a).
- Health Care Financing Administration, Department of Health and Human Services, "Link between Medicaid and SSI Coverage of Children under Welfare Reform," Fact Sheet #2, 1996b.
- Health Care Financing Administration, Department of Health and Human Services, "Link between Medicaid and Temporary Assistance for Needy Families," Fact Sheet #1, 1996c.
- Health Care Financing Administration, Department of Health and Human Services, "Link between Medicaid and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996," Fact Sheet #3, 1996d.
- Health Care Financing Administration, Department of Health and Human Services, *Section 1915(b) Freedom of Choice Waivers* (Baltimore: 1996e).



- Health Care Financing Administration, Department of Health and Human Services, *Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 1996* (Baltimore: 1997).
- Holahan, John, and David Liska, *Where is Medicaid Spending Headed?* (Washington, DC: Kaiser Commission on the Future of Medicaid, December 1996).
- Holahan, John, and David Liska, "The Slowdown in Medicaid Spending Growth: Will It Continue?" *Health Affairs* 16(2), March/April 1997, forthcoming.
- Holahan, John, Diane Rowland, Judith Feder, and David Heslam, "Explaining the Recent Growth in Medicaid Expenditures," *Health Affairs* 12(3)177-193, Fall 1993.
- Horvath, Jane, and Neva Kaye, eds., *Medicaid Managed Care: A Guide for States*, Second Edition (Portland, ME: National Academy for State Health Policy, 1995).
- Horvath, Jane, and Neva Kaye, *Enrollment and Disenrollment in Medicaid Managed Care Program Management*, (Portland, ME: National Academy for State Health Policy, December 1996).
- Horvath, Jane, and Neva Kaye, eds., *Medicaid Managed Care: A Guide for States*, Third Edition (Portland, ME: National Academy for State Health Policy, 1997).
- Kaiser Commission on the Future of Medicaid, *Medicaid Facts: Medicaid and Managed Care*, Fact Sheet (Washington, DC: May 1996a).
- Kaiser Commission on the Future of Medicaid, *Medicaid Facts: Medicaid Enrollment and Spending Growth*, Fact Sheet (Washington, DC: December 1996b).
- Kaiser Commission on the Future of Medicaid, *Medicaid Facts: The Medicaid Program at a Glance*, Fact Sheet (Washington, DC: November 1996c).
- Kaiser Commission on the Future of Medicaid, *Medicaid Facts: The Medicaid Program at a Glance*, Fact Sheet (Washington, DC: 1997a, forthcoming).
- Kaiser Commission on the Future of Medicaid, unpublished calculations, March 1997b.
- Lazenby, Helen, Katharine R. Levit, and Daniel R. Waldo, "National Health Expenditures, 1985," *Health Care Financing Notes* 6:1-32, September 1986.
- Levit, Katharine R., Helen C. Lazenby, and Lekha Sivarajan, "Health Care Spending in 1994: Slowest in Decades," *Health Affairs* 15(2):130-144, Summer 1996.

- Lewin-VHI, *States as Payers: Managed Care for Medicaid Populations* (Washington, DC: National Institute for Health Care Management, February 1995).
- Liska, David, Karen Obermaier, Anuj Shah, and Alina Salganicoff, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1988-1994*, Second Edition (Washington, DC: Kaiser Commission on the Future of Medicaid, November 1996).
- National Health Policy Forum, *Impact of the New Welfare Law on Medicaid*, Issue Brief No. 697 (Washington, DC: February 7, 1997).
- Page, Leigh, "HMOs Back Away from Medicaid," *American Medical News* 40(2):3, 22, January 13, 1997.
- Physician Payment Review Commission, *Annual Report to Congress 1993* (Washington, DC: 1993).
- Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).
- Physician Payment Review Commission, *Annual Report to Congress 1996* (Washington, DC: 1996).
- Sparer, Michael, and Karyen Chu, *Managed Care and Low-Income Populations: A Case Study of Managed Care in New York* (Menlo Park, CA: Henry J. Kaiser Family Foundation, October 1996).
- Sparer, Michael S., Marilyn R. Ellwood, and Cathy Schoen, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Minnesota* (Menlo Park, CA: Henry J. Kaiser Family Foundation, May 1996a).
- Sparer, Michael S., Marsha Gold, and Lois Simon, *Managed Care and Low-Income Populations: A Case Study of Managed Care in California* (Menlo Park, CA: Henry J. Kaiser Family Foundation, May 1996b).
- United Hospital Fund, "The Impact of Federal Welfare Reform," *Currents: Medicaid Managed Care* 1(3), Fall 1996a.
- United Hospital Fund, "New Plans Enter Program; Current Plans Also Renewed," and "Medicaid Managed Care Legislation Passed," *Currents: Medicaid Managed Care* 1(3), Fall 1996b.
- Wooldridge, Judith, Leighton Ku, Teresa Coughlin, et al., *Reforming State Medicaid Programs: First-Year Implementation Experiences from Three States* (Princeton: Mathematica Policy Research, January 1997).

# Update on Provider-Sponsored Organizations and the Antitrust Laws

The system of antitrust laws and enforcement policies is designed to maintain a procompetitive environment in markets. As health care markets evolve, provider groups have raised concerns over uncertainty about which forms of joint ventures would (or should) be considered legitimate under current law. Several steps have been taken by the principal federal antitrust law enforcement agencies to ease these concerns.

In 1993 and 1994, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) released a series of statements intended to clarify instances (referred to as safety zones) that would not be subject to investigation for antitrust violations. In addition, the agencies have an ongoing program of advising the public about the legality of proposed ventures.

The Physician Payment Review Commission first examined the issues related to applying the antitrust laws to physician-sponsored networks in its 1995 annual report (PPRC 1995). It noted that although complying with current laws may be cumbersome, these laws did not preclude physicians from forming such networks. It concluded, therefore, that there was no compelling reason for granting exemptions from the antitrust laws.

In August 1996, the DOJ and the FTC released a new set of enforcement statements. This appendix describes these new statements. It begins with a brief overview of antitrust law and enforcement policy. Next, the policy issues and evidence are summarized. A description of past efforts by the agencies to clarify their enforcement policies follows. Finally, the 1996 enforcement statements are discussed.



## BRIEF OVERVIEW OF THE ANTITRUST LAWS AND ENFORCEMENT POLICY

The intent of the antitrust laws is to benefit consumers by maintaining a competitive environment for the production and distribution of goods and services. The laws accomplish this through a combination of outright prohibitions of certain practices that have been deemed blatantly anticompetitive, and case-by-case analyses of practices that may or may not be anticompetitive.

### Antitrust Laws

Both the federal government and the states enact and enforce antitrust laws. For the most part, state-level laws are similar in content to the federal statutes. At the federal level, antitrust enforcement is carried out under the provisions of the Sherman Act (1890), the Clayton Act (1914), and the Federal Trade Commission Act (1914). The Sherman Act prohibits concerted actions by two or more competitors to restrain trade, monopolization, and attempts to monopolize by one or more competitors. The Clayton Act extended and added to the Sherman Act prohibitions by declaring the following illegal: price discrimination, tying or exclusive dealing contracts, and corporate mergers and acquisitions when the effect may be to substantially lessen competition or create a monopoly.<sup>1</sup> In addition, the Clayton Act gave private parties the right to bring suit to recover treble damages for injuries they suffered from violations of the antitrust laws. Finally, the Federal Trade Commission Act created the FTC as an independent agency to investigate unfair methods of competition and other unfair or deceptive acts and practices.<sup>2</sup>

### Enforcement Policy

The general approach used in analyzing health care joint ventures, such as provider-sponsored organizations (PSOs), consists of determining whether the venture significantly restricts competition. If it does, the next step is to determine whether the restriction is reasonably necessary to accomplish some feature or activity of the joint venture that is likely on the whole to be beneficial to consumers.

One important factor in this analysis is whether the joint venture involves real economic integration among its participants in order to create a new competitor in the market, or whether it is merely a convenient structure for raising prices or otherwise exploiting consumers. In the past, the enforcement agencies have placed considerable weight upon whether the venture involves the sharing of substantial financial risk as an indicator of economic integration. As discussed below, criteria other than financial risk sharing also will be used by the agencies as indicators of economic integration.

---

<sup>1</sup> Price discrimination occurs when a supplier is able to sell the same product to different consumers for different prices. A tying agreement is one in which a seller is only willing to sell one good if the purchaser agrees to buy a second good. An example would be an automobile dealership that requires customers to use the dealership's service department for all repairs and maintenance as a condition of the purchase agreement.

<sup>2</sup> This includes all acts and practices covered by the Sherman and Clayton Acts.

If a joint venture does not involve significant economic integration, then certain activities could be challenged as per se violations of the antitrust laws. Under the per se rule, certain practices are deemed to be sufficiently anticompetitive in most circumstances that it is not necessary to consider whether the activity actually resulted in injury in a specific situation. These practices include price fixing, market allocation agreements, tying agreements, boycotts, and other agreements among competing firms to restrain competition.

Joint ventures that are not economically integrated, however, are not necessarily subject to per se condemnation. As long as they do not engage in the set of activities deemed to be per se violations, the overall merits of the venture would then be examined according to a rule-of-reason analysis. For example, a nonfinancially integrated physician-owned preferred provider organization (PPO) can avoid per se condemnation by using a messenger model to set prices (DOJ/FTC 1994). Under this model, venture participants do not exchange any information among themselves about prices. Instead, a third party (referred to as a messenger) is used as an intermediary between each individual member of the joint venture and the purchaser.<sup>3</sup>

If the joint venture is deemed legitimate (i.e., not merely a vehicle for anticompetitive conduct), then its activities that appear to be restrictions on competition could be examined under a rule-of-reason analysis to determine if the procompetitive attributes of the venture outweigh any of its anticompetitive effects. Whether the venture is actually subject to further examination would be determined by a number of factors, including its potential for affecting the overall market.

## THE ISSUES

Providers have raised two general issues about the current system of antitrust laws and enforcement policies. First, uncertainty about which types of joint ventures would be subject to challenge may create a chilling effect on the formulation of new and innovative means of delivering health care. This chilling effect may be disproportionately larger on smaller enterprises, such as those organized by physicians and other providers, because these ventures would have fewer financial resources to devote to fending off antitrust challenges.

Second, the provider community has raised concerns about whether current enforcement policy unduly restricts providers' ability to compete effectively in the medical marketplace (Bierig 1995; Hirshfeld 1994; Todd 1993). For example, physicians argue they are blocked from organizing to offset increasing market dominance by insurers. Under the antitrust laws, attempts by physicians to negotiate payment rates collectively to offset insurer dominance may be subject to per se condemnation. In addition,

---

<sup>3</sup> For example, if a joint venture has three participants (A, B, and C), then the messenger would convey price information between the purchaser and member A, the purchaser and member B, and the purchaser and member C in three separate and independent exchanges. In this way, prices are determined in a noncollusive fashion between the purchaser and the members of the joint venture.

providers argue that to reduce the prospects of antitrust challenges, they face higher costs in establishing plans relative to insurers. Restrictions on network size, or being compelled to use a messenger model to negotiate prices, might offset any efficiencies PSOs would have relative to insurer-based plans.

Some antitrust law scholars also have raised concerns that the enforcement agencies are too quick to presume that provider-sponsored networks are anticompetitive (Havighurst 1995). The argument is that, even though risk sharing and integration are reasonable indicators that a network is procompetitive, a network lacking these indicators may also be procompetitive. All networks, therefore, should at least be given an abbreviated rule-of-reason examination of the plausibility of any procompetitive claims before determining if the appropriate course should be a per se challenge or a full rule-of-reason analysis.

## **THE EVIDENCE**

The evidence does not readily lend support to the notion of antitrust enforcement policy chilling the development of PSOs. First, contrary to common perceptions, provider-sponsored networks and other provider joint ventures rarely have been challenged at the federal level. For example, only 15 of 397 hospital mergers between 1981 and 1993 were challenged. Between 1986 and 1994, the enforcement agencies raised concerns with only 1 of 20 proposed physician-sponsored organizations brought before them for preliminary review (PPRC 1995).<sup>4</sup> Up to 1994, the FTC challenged only two existing physician-sponsored organizations as per se violations of the antitrust laws (Horoschak 1994). More recently, during 1995 and 1996, the DOJ challenged 3 existing PSOs and raised concerns with 2 of 22 proposed PSOs.<sup>5</sup>

Second, PSOs (in one form or another) appear to have experienced considerable growth over the last several years (see Chapter 10). Multiple surveys have found providers either actively participating in a PSO or considering involvement in one. Although this does not address the question of how many PSOs would exist in the absence of current enforcement policy, it does indicate that these entities are managing to enter the marketplace in significant numbers.

## **PAST ACTIONS BY THE AGENCIES TO REDUCE ENFORCEMENT UNCERTAINTY**

Over the last few years, in response to professional and congressional concerns, the DOJ and the FTC have taken a number of actions to clarify how the antitrust laws will be enforced in health care markets. The most significant steps have been the joint release of two sets of policy statements

---

<sup>4</sup> Based on a review of FTC advisory opinions and DOJ business review letters.

<sup>5</sup> The three challenges concerned situations where a physician-hospital organization included almost all of the local providers.



specifying safety zones from antitrust challenges. In addition, the agencies have implemented steps to inform the industry on an expedited basis about possible challenges to specific proposed arrangements.

### **The DOJ/FTC 1993 and 1994 Antitrust Enforcement Policy Statements**

In an effort to clarify their enforcement policies, in September 1993, the DOJ and the FTC jointly released a set of statements indicating six safety zones in which neither agency would challenge on antitrust grounds (DOJ/FTC 1993).<sup>6</sup> In regard to physician activities, absent extraordinary circumstances, the agencies would not challenge the following:

- The collective provision by physicians of medical information to help purchasers of their services resolve issues about the mode, quality, or efficiency of medical treatment;
- Joint-purchasing arrangements among health care providers, as long as they meet conditions designed to ensure they do not become vehicles for collusive purchasing or for price fixing; and
- Physician network joint ventures made up of no more than 20 percent of the physicians in any specialty in a geographic market who have active hospital staff privileges and who share substantial financial risk.

These initial statements were clarified and expanded with a new set of nine statements that were released in September 1994 (DOJ/FTC 1994). The key changes to the original statements were:

- Addition of statements on (1) safety zones for hospital joint ventures involving specialized clinical or other expensive health care services; (2) safety zones for providers' collective provision of fee-related information to purchasers of health care services (e.g., a survey of providers' fees done by a third party); and (3) analytical principles that would be applied in reviewing multiprovider networks (e.g., physician-hospital organizations); and
- Expansion of the physician network joint venture safety zone from 20 percent to 30 percent of physicians in any specialty in a given geographic market for nonexclusive joint ventures.<sup>7</sup>

---

<sup>6</sup> Three statements apply to physician activities. The other three statements concern hospital mergers, hospital joint ventures involving high-technology equipment, and exchanges of price and cost information among hospitals.

<sup>7</sup> A nonexclusive network is defined as one that does not impose any significant restrictions on the ability of its member providers to affiliate with other networks, whereas an exclusive network imposes such restrictions on its member providers (DOJ/FTC 1994). The safety zone was kept at 20 percent for exclusive joint ventures.

## **Expedited DOJ Business Reviews and FTC Advisory Opinions**

The agencies have offered to provide expedited business reviews and advisory opinions on any matter contained in the enforcement statements within 90 to 120 days of receiving all material necessary to respond.<sup>8</sup>

### **THE 1996 DOJ/FTC ENFORCEMENT STATEMENTS**

The purpose of the 1996 enforcement statements was to offer additional clarification on antitrust enforcement policy. The statements provide more guidance on the set of antitrust safety zones and on the circumstances under which the enforcement agencies might challenge an activity as a per se violation of the antitrust laws, or examine it under a rule-of-reason analysis.

The most significant changes between the 1994 and 1996 statements concern physician network joint ventures.<sup>9</sup> There are essentially four parts to the statement on these ventures. The first part concerns the size of the antitrust challenge safety zones. The safety zones are identical to those given in the 1994 statements. For exclusive networks, the safety zone is 20 percent or less of physicians in any one specialty with hospital staff privileges. For nonexclusive physician network joint ventures, the safety zone is 30 percent or less. The agencies, however, have made it clear that ventures falling outside of the safety zones will not necessarily be challenged.

The second part of the statement provides detail on what the agencies view as substantial financial risk. As previously noted, the sharing of substantial financial risk is considered by the agencies to be a key indicator that the joint venture involves real economic integration and is not merely a vehicle for engaging in anticompetitive activities. Under the 1994 statements, substantial financial risk was defined, by two examples, as: (1) capitated payments; or (2) financial incentives for the venture's members to meet cost containment goals, such as partial payment withholds.<sup>10</sup> The 1996 statements expanded this set to include two additional examples: (1) payment based on a predetermined percentage of premiums or revenue from a plan, and (2) global payments for complex or extended courses of treatment.

---

<sup>8</sup> These business reviews and advisory opinions should not be confused with rule-of-reason analyses. The former are brief opinions, based on information provided to the agencies, about whether proposed ventures run the risk of violating the antitrust laws. The latter are formal analyses that encompass considerably more information collection and analysis.

<sup>9</sup> There are nine enforcement statements. The first seven statements concern hospital mergers, joint ventures for purchasing high-technology equipment and expensive health care services, and the collective provision and exchange of price and cost information. Because these statements are not the focus of current concerns with antitrust policy and did not change from the 1994 enforcement statements, they are not discussed here. Finally, because the statement on multiprovider networks was subject to the same changes as the physician network joint venture statement, it is not discussed here either.

<sup>10</sup> In addition, other unspecified forms of economic integration that amount to the sharing of substantial financial risk would be considered.

The third part of the statement provides additional guidance on whether a joint venture that falls outside of the safety zones would be challenged under per se rules or examined under rule-of-reason analysis. Under the 1994 statement, a joint venture that fell outside of the safety zone would still be examined under rule of reason if (1) substantial financial risk was shared, or (2) combining the physicians into a joint venture would enable them to offer a new product that produces substantial efficiencies.

In the 1996 statement this second criterion was broadened to cover other nonfinancial forms of integration likely to produce significant efficiencies benefiting consumers. In addition to offering a new product, implementation of physician practice pattern evaluation and modification programs that create a high degree of interdependence to control costs and ensure quality would be covered under this criterion. Such programs may include (1) establishing mechanisms to monitor and control utilization, (2) selectively choosing physicians who are likely to further efficiency objectives, and (3) significantly investing in monetary and human capital to realize the claimed efficiencies.

The fourth part of the statement provides clarification on the types of messenger models that could be used in price negotiations by nonintegrated networks to avoid per se challenges. According to the 1994 statements, the only role a third-party messenger could play in price negotiations was to communicate information between the prospective purchaser and each individual provider in the network. The critical feature of the previously approved model was that individual providers made their own separate decisions about whether to accept or reject a proposal. According to the new statement, the messenger can assume a larger role by actively accepting or rejecting offers on behalf of providers according to predetermined instructions.

## **CONCLUSIONS**

With these new statements, the enforcement agencies have taken a significant step toward clarifying which provider-sponsored joint ventures would be subject to potential antitrust challenges. The case-specific nature of enforcement policy, however, makes it difficult to cover every situation where an activity might be subject to challenge. Only through experience, therefore, will it become apparent which aspects of enforcement policy might need additional clarification.

Several questions arise, for example, on the two additional forms of payment that would be considered to represent substantial financial risk. The first question concerns how narrowly (or broadly) the agencies are defining the range of services covered under a global payment structure. The agencies indicated in an example that a global payment to a multiprovider network covering all inpatient, outpatient, and ancillary services related to bone marrow transplants would be acceptable. For purely horizontal physician networks, it is unclear if physicians would be held at risk for services provided outside of the network (i.e., hospital services).



Further, there is no guidance on how the agencies view blended payment structures such as partial capitation. These types of payment arrangements are an integral part of the Health Care Financing Administration's Medicare Choices Demonstration, and could perhaps benefit from additional clarification.

In addition, it may take some time to clarify how the new criteria on nonfinancial forms of integration would be implemented. For example, it is not clear how much monetary and human capital is needed for a program to be deemed a bona fide cost control or quality assurance program. Also, it is uncertain whether the agencies would be actively involved in determining the acceptability of cost control and quality assurance programs, or if they would turn to outside accrediting boards for such determinations.

Finally, the expansion of the messenger model has the potential to reduce transaction costs and, hence, makes it a more attractive alternative for providers that are hesitant to engage in more integrated joint ventures. As with the other changes, however, the true impact of this expansion can only be determined by observing if more providers adopt this approach in setting up networks.

## REFERENCES

Bierig, Jack R., *Antitrust and Physician Involvement in Managed Care: Reform is Needed!*, paper presented to the Physician Payment Review Commission, January 11, 1995.

Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in the Health Care Area*, September 15, 1993.

Department of Justice and the Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, September 27, 1994.

Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, August 28, 1996.

Havighurst, Clark C., *Are the Antitrust Agencies Overregulating Physician Networks?*, unpublished paper, October 3, 1995.

Hirshfeld, Edward B., *The Case for Antitrust Reform for Physician Groups* (Chicago: American Medical Association, June 8, 1994).

Horoschak, Mark J., Bureau of Competition, Federal Trade Commission, oral testimony before the Physician Payment Review Commission, October 28, 1994.

Physician Payment Review Commission, *Annual Report to Congress 1995* (Washington, DC: 1995).

Todd, James S., "Physicians as Professionals, Not Pawns," *Health Affairs*, 12(3):145-147, Fall 1993.

# Commission Members

GAIL R. WILENSKY, Ph.D., is Chair of the Commission. As Project HOPE's John M. Olin Senior Fellow, she analyzes and develops policies relating to health care reform and ongoing changes in the medical marketplace. She also frequently advises members of Congress and others on the policies and politics of health care reform. Dr. Wilensky has held several posts in the Executive Branch, most recently as deputy assistant to the President for policy development during the Bush Administration and, before that, as administrator of the Health Care Financing Administration. Recipient of numerous professional awards, she is a member of the Institute of Medicine of the National Academy of Sciences, a trustee of the Combined Benefits Fund of the United Mine Workers of America, a governor for the Research Triangle Institute, and a member of the National Research Council's Board on Children and Families. In addition to serving on many other professional committees and corporate boards, Dr. Wilensky is a well-known speaker who has published widely on health policy, economics, and financing. She received a bachelor of arts degree in psychology and a doctorate in economics at the University of Michigan.

LINDA H. AIKEN, Ph.D., is trustee professor of nursing; professor of sociology; director of the Center for Health Services and Policy Research; and senior fellow at the Leonard Davis Institute for Health Economics, University of Pennsylvania. Before joining the university faculty in 1988, she was vice president of the Robert Wood Johnson Foundation for 13 years. Dr. Aiken is a frequent adviser to federal and state policymakers. She has written numerous scientific and policy papers on access to and the organization and financing of health services, particularly AIDS care and health work force policy. Dr. Aiken is a member of the Institute of Medicine of

the National Academy of Sciences and the National Academy of Social Insurance. A former president of the American Academy of Nursing, Dr. Aiken was also a member of the 1982 Social Security Advisory Council and has served on national advisory groups on the organization and financing of long-term care for the elderly. Dr. Aiken received nursing degrees from the University of Florida at Gainesville, and a doctorate in sociology and demography from the University of Texas at Austin.

RICHARD V. (DICK) ANDERSON, is vice president of health policy for the Kaiser Permanente Foundation Health Plan. He is responsible for developing government relations positions and strategy regarding public policy issues that affect the company. During his 28-year tenure at Kaiser Permanente, he has led corporate marketing support and medical economics activities. His responsibilities have included the coordination of services for national employers, product development and planning, market research, pricing services, data reporting, and analysis. He represents Kaiser Permanente in its relationships with an array of government entities, health care organizations, employers, health benefits consultants, business coalitions, and others. Mr. Anderson is actively involved with the American Association of Health Plans and the Washington Business Group on Health, serving on various committees and work groups. He received a bachelor of science degree from Washington State University and a master's of public health from the University of California, Berkeley. Additionally, Mr. Anderson attended the University of Washington and completed the Harvard Business School's Advanced Management Program.

GILES G. BOLE, M.D., is dean emeritus of the University of Michigan Medical School, where he has served for 30 years in various faculty and administrative positions, including senior associate dean, executive associate dean, and dean. A specialist in rheumatology, he has been active in both clinical and laboratory investigations. Before being appointed as senior associate dean, Dr. Bole was the director of the Rackham Arthritis Research Unit, chief of Rheumatology, and director of the University of Michigan's Multipurpose Arthritis Center. He has recently been a member of the Association of American Medical Colleges' advisory panel on Strategic Positioning for Health Care Reform and the Academic Health Center Working Group. Dr. Bole has been associated with the American Board of Internal Medicine, the National Institutes of Health, the Centers for Disease Control, the American College of Physicians, the American College of Rheumatology, and the Arthritis Advisory Committee of the Food and Drug Administration. He is the author of many peer-reviewed journal articles and book chapters, and has served on the editorial board of *Arthritis and Rheumatism* and *Annals of Internal Medicine*. Dr. Bole received a medical degree from the University of Michigan where he also completed an internship and residency in internal medicine.

P. WILLIAM CURRERI, M.D., is president of Strategem of Alabama, Inc., an international health care marketing and consulting firm. Dr. Curreri has served as professor, chairman, and chief of surgery at the University of South Alabama in Mobile. He was also on the faculties of the University of Washington School of Medicine in Seattle and Cornell Medical Center in New York. Dr. Curreri is a former president of the American Burn Association, the Society of University Surgeons, the Halstead Society, and the American Association for the Surgery of Trauma. Author of numerous articles on



surgery, Dr. Curreri is a consultant to and member of the editorial boards of several major surgical and burn care journals and a past editor-in-chief of *The American Surgeon*. A frequent adviser to the National Institutes of Health, Dr. Curreri was a member of its Surgery, Anesthesia, and Trauma Study Section from 1980 to 1988, and chair from 1986 to 1988. He is also a member of the American Board of Surgery and is a former member of the executive committee of the board of governors of the American College of Surgeons, where he was secretary from 1987 to 1989. Dr. Curreri received a medical degree from the University of Pennsylvania and completed a surgical residency at the Hospital of the University of Pennsylvania.

ANNE B. JACKSON is a member of the National Legislative Council of the American Association of Retired Persons and serves as chairperson of the Health and Future Generations Committee. A registered nurse for 45 years, she retired in 1989. Mrs. Jackson was a professor in the Department of Nursing at City University of New York, and served in the positions of medical supervisor, head nurse, and staff nurse for the Veterans Administration (now the Department of Veterans Affairs). She is a member of the Institute of Medicine's Roundtable on Research and Development of Drugs, Biologics, and Medical Devices. Mrs. Jackson received a bachelor's degree in education from Hunter College and a master's in nursing administration from Columbia University Teacher's College.

DONALD T. (TED) LEWERS, M.D., a practicing nephrologist and internist, is also on the staff at the Memorial Hospital at Easton in Maryland. A member of the board of trustees of the American Medical Association, Dr. Lewers is medical director of the Easton Renal Treatment Center, chair of the board and chief executive officer of the Medical Mutual Liability Insurance Company of Maryland, and chair of the board of the Health Enhancement Center, Inc. Long active in organized medicine, Dr. Lewers served as president of the Medical and Chirurgical Faculty of Maryland from 1985 to 1986 and was vice chair of the American Medical Association's Relative Value Scale Update Committee. Dr. Lewers received a bachelor's degree from the University of Maryland and medical degree from the University of Maryland School of Medicine. He completed an internship at the University of Maryland Hospital in Baltimore, a residency at Maryland General Hospital in Baltimore, and a fellowship in nephrology at Georgetown University Hospital in Washington, D.C.

MARK V. PAULY, Ph.D., is vice dean of the Wharton Doctoral Programs and Bendheim Professor. He is professor of health care systems, insurance and risk management, and public policy and management at the Wharton School, and professor of economics in the School of Arts and Sciences at the University of Pennsylvania. He served as executive director of the Leonard Davis Institute of Health Economics from 1984 to 1989 and as director of research from 1989 to 1995. Dr. Pauly is a member of the Institute of Medicine of the National Academy of Sciences, and adjunct scholar of the American Enterprise Institute. He has been a member of the technical advisory panels to the National Institute of Drug Abuse, the Health Care Financing Administration's Division of National Cost Estimates, and the Advisory Council on Social Security. He has been on the editorial boards of the *Journal of Health Economics*, *Public Finance Quarterly* and several other professional journals. Dr. Pauly has published more than 100 journal articles and books in the fields of health economics,

public finance, and health insurance. He received a master's degree from the University of Delaware and a doctorate in economics from the University of Virginia.

PATRICIA E. POWERS is the executive director of the Pacific Business Group on Health (PBGH), (formerly the Bay Area Business Group on Health), a nonprofit coalition of 33 large private and public-sector employers which have annual health expenditures in excess of \$3 billion. She is also president of its subsidiary, the PBGH Negotiating Alliance. Ms. Powers was formerly project director of the Bay Area Health Task Force on the Working Uninsured, a Robert Wood Johnson Foundation effort to expand health insurance among uninsured small businesses and self-employed persons. Prior to that, she was a presidential management intern and policy analyst in Washington, DC. Ms. Powers is a board member of the National Committee on Quality Assurance and the National Business Coalition on Health. She received her undergraduate degree from the University of Michigan and a master's in public policy and administration from Columbia University.

FRANK A. SLOAN, Ph.D, is the J. Alexander McMahon Professor of Health Policy and Management and professor of economics at Duke University. Before joining the university faculty in 1993, he was a research economist at the RAND Corporation and served on the faculties of the University of Florida and Vanderbilt University. His current research focuses on alcohol use prevention, long-term care, medical malpractice, Medicaid managed care, and cost-effectiveness analyses of medical technologies. Dr. Sloan has served on several national advisory groups, and is a member of the Institute of Medicine of the National Academy of Sciences. Dr. Sloan received an undergraduate degree from Oberlin College and a doctorate in economics from Harvard University.

EARL P. STEINBERG, M.D., is vice president of Covance Health Economics and Outcomes Services, Inc. and director of Covance's Quality Assessment and Improvement Systems Division. His work focuses on technology assessment; the design, implementation, and management of outcomes and quality assessment systems for providers; and the development of tools that promote cost-effective care. Dr. Steinberg is also a professor of medicine at Johns Hopkins University School of Medicine, and has a joint faculty appointment in the Department of Health Policy and Management of the Johns Hopkins School of Hygiene and Public Health. He currently serves as a member of the national Blue Cross and Blue Shield Association's medical advisory panel. Dr. Steinberg oversees the design and implementation of national outcomes databases for the American Academy of Ophthalmology and the American Academy of Otolaryngology/Head and Neck Surgery. He has received numerous awards, including the Henry J. Kaiser Family Foundation Faculty Scholar Award in General Internal Medicine and the Outstanding Young Investigator Award from the Association for Health Services Research. Dr. Steinberg received his medical degree from Harvard Medical School, and a master's of public policy degree from the Kennedy School of Government. He completed a residency in internal medicine at Massachusetts General Hospital.

RAY E. STOWERS, D.O., is an osteopathic family physician who has been in solo primary care practice in the rural, underserved community of Medford, Oklahoma since 1974. Dr. Stowers has been a member of the American Medical Association's Relative Value Scale Update Committee since

1992. He currently chairs the advisory council that oversees the Oklahoma State University College of Osteopathic Medicine, where he serves as an adjunct professor and designed the preventive medicine curriculum. Dr. Stowers also chairs the governance committee of the Oklahoma Physician Manpower Training Commission and is a member of the American Osteopathic Association's Council on Federal Health Programs. He is a fellow of the American College of Family Practice in Osteopathic Medicine and Surgery, and former president of the Oklahoma Osteopathic Association. He has also served on numerous professional councils and task forces. Dr. Stowers received a degree in osteopathic medicine from the University of Health Sciences, College of Osteopathic Medicine in Kansas City, Missouri.

ROGER S. TAYLOR, M.D., is president and chief executive officer of Connecticut Health Enterprises, a developing integrated health care delivery system. Dr. Taylor has over 25 years of health care management experience, including the development and administration of every form of managed-care product available today. He previously served as executive vice president and chief medical officer of PacifiCare Health Systems; national leader of health care consulting for the Wyatt Company; senior vice president, EQUICOR, Inc.; president, Corporate Health Care Management; senior vice president and co-founder, United Medical Plans, Inc.; and regional medical director, CIGNA Health Plans of California. Dr. Taylor has served in a number of other policy-related roles, including president and co-founder of the Utilization Review Accreditation Commission; commissioner, California Health Facilities Commission; and director of California's Emergency Medical Services Authority. He is a well-known speaker and writer on health care issues and has consulted internationally on health reform. Dr. Taylor received a medical degree from the University of Southern California School of Medicine and a master's degree in public administration from the University of Southern California School of Public Administration.



---

# Commission Staff

LAUREN B. LeROY, Ph.D., is executive director. She joined the Commission at its inception in 1986, serving first as deputy director and assuming the responsibilities of executive director in 1995. Before coming to the Commission, Dr. LeRoy was associate director of the Commonwealth Fund Commission on Elderly People Living Alone. She spent more than a decade at the Institute for Health Policy Studies, University of California, San Francisco, where she was assistant director and then director of the Institute's Washington office. She was also an analyst working on health issues in the Department of Health, Education, and Welfare. Dr. LeRoy's research interests and published work have focused on Medicare reform, physician training and practice, the nurse labor market, and health care for the elderly. She is a member of the National Academy of Social Insurance, a fellow of the Association for Health Services Research, and serves on the Association for Health Services Research's Health Administration Press editorial board. She received a doctorate in social policy planning from the University of California, Berkeley.

DAVID C. COLBY, Ph.D., is deputy director. Before joining the Commission in 1988, he held faculty and administrative positions at Williams College and the University of Maryland, Baltimore County. From 1986 to 1987, he was a Robert Wood Johnson health finance fellow. Dr. Colby's published research has focused on Medicaid and Medicare, AIDS politics and policies, and various topics in political science. He is an associate editor of the *Journal of Health Politics, Policy and Law*. He received his doctorate in political science from the University of Illinois.

DONALD F. COX, Ph.D., is a senior analyst. Before joining the Commission, he was a senior economist at the Federal Trade Commission and Fu Associates, Ltd. In addition, he has worked in the Occupational Safety and Health Administration and the Department of Defense. His work at the Commission has involved application of antitrust laws to physician networks, competitive bidding, analysis of the effect of Medicare payment policies on physicians and private payers, and risk selection and adjustment. He received a doctorate in economics from the University of Maryland.

CHRISTINE M. CUSHMAN is an analyst. Her recent work at the Commission focuses on consumer protection initiatives for managed care, the financial liability of Medicare beneficiaries, and provider-sponsored organizations. She received a master's degree in public policy from Georgetown University.

ELIZABETH DOCTEUR is a senior analyst. Her recent work at the Commission has focused on access to care in Medicare risk plans, health plan performance measures, and beneficiaries who are dually eligible for Medicare and Medicaid. Her previous work addressed clinical practice guidelines, health plan participation standards for Medicare, and Medicare quality assurance strategies. She formerly worked at Strong Memorial Hospital in Rochester, New York, where she served as an intern in the medical center's strategic planning office. She received a master's degree in public policy analysis from the University of Rochester.

DIANE ELLISON is the office manager. Before joining the Commission, she spent 18 years working for U.S. Senator Bill Bradley. She served as the assistant to the Senator's chief of staff and later as the Senator's office manager. At the Commission, she is responsible for financial management, personnel, meeting planning, and other office operations.

KEVIN HAYES, Ph.D., is a senior analyst. His work at the Commission focuses on analysis of claims and survey data to monitor Medicare beneficiaries' access to care. Previously, he held various local and federal health care planning positions. He received a doctorate in health policy and administration from the University of North Carolina at Chapel Hill.

ANNETTE HENNESSEY is the outgoing executive assistant. Before joining the Commission, she worked for U.S. Senator Bill Bradley, where she was primarily responsible for administration of the legislative staff. As assistant to the executive and deputy directors, she has assisted in managing Commission operations. She received a bachelor's degree in political science from Mississippi State University in Starkville.

JOHN F. HOADLEY, Ph.D., is a principal policy analyst. Before joining the Commission, he taught political science at Duke University, was a congressional fellow and legislative assistant for U.S. Representative Barbara B. Kennelly, and developed educational sessions for policymakers at George Washington University's National Health Policy Forum. Dr. Hoadley's current work at the Commission centers around Medicare managed care, provider-sponsored organizations, and Medicaid. Previously, he has worked on other issues including health system reform, data systems, the Medicare

Fee Schedule, risk adjustment, global budgets, and beneficiary perspectives on Medicare reform. He received a doctorate in political science from the University of North Carolina at Chapel Hill.

CHRISTOPHER HOGAN, Ph.D., is a principal policy analyst. His recent work at the Commission has focused on risk adjustment and improving the performance of traditional fee-for-service Medicare. In prior years, he conducted analyses of private insurers' fees, areas of poor access to care, and medical savings accounts. He has also worked on such issues as the Medicare Volume Performance Standard system and Medicare beneficiaries' access to care. He holds a doctorate in economics from Northwestern University.

DEBORAH F. KRAMER is the incoming executive assistant. Before joining the Commission she was a confidential assistant in the Executive Office of the President in the Office of Management and Budget and a legislative aide in the office of U.S. Senator Bill Bradley. At the Commission, she oversees the production of publications and is responsible for computer network operations. She received a bachelor's degree in public administration from Nichols College in Dudley, Massachusetts and is currently pursuing a master's degree in computer information systems.

KATIE MERRELL is a senior analyst. Before joining the Commission staff, she worked for Abt Associates in the areas of health economics research, income support, and education. She was also a research assistant for the board of governors of the Federal Reserve System, and a high school mathematics and computer science teacher. Her work at the Commission has focused on Medicare risk-plan payment policies, practice expense, geographic adjustment of the Medicare Fee Schedule, simulating the effect of policy changes on fee schedule payments, and other issues, including the structure of the health insurance market and community rating. She spends a portion of her time at the Center for Health Administration Studies, University of Chicago.

MICHAEL J. O'GRADY, Ph.D., is a senior analyst. Before joining the Commission, he worked for the Department of Health, Education and Welfare, the Department of Education's Office for Civil Rights, and for the Education and Public Welfare Division of the Congressional Research Service as a Specialist in Social Legislation. His work at the Commission focuses on exploring the implications of moving Medicare to a defined contribution system. He holds a doctorate in political science from the University of Rochester.

ANNE L. SCHWARTZ, Ph.D., is special assistant to the executive director. Since joining the Commission staff, her analytical work has addressed a range of Medicare and Medicaid issues, including graduate medical education financing, physician payment and access under Medicaid, and financial protection for Medicare beneficiaries. Most recently, she has focused on the changing labor market for physicians and the effects of the evolving health care market on academic medical centers. Previously, she held various positions as a staff member in the U.S. House of Representatives. She received a doctorate in health policy from the Johns Hopkins University.



DAVID W. SHAPIRO, M.D., J.D., is a senior analyst. After completing a residency in primary care internal medicine, he was a Veterans Administration/Robert Wood Johnson clinical scholar. At the Commission, he has worked on a variety of topics, including Medicare coverage decisions and the appeals process, medical liability reform, the Medicare Fee Schedule, and data capabilities of health plans. He received a medical degree from the University of California, Los Angeles, and a law degree from Yale University.

SALLY TRUDE, Ph.D., is a senior analyst. Before joining the Commission staff, Dr. Trude was an associate policy analyst at RAND working on physician payment issues. This year, her work at the Commission included expenditure limits for Medicare fee for service and issues of access for vulnerable groups in Medicare managed care. Previously, she has studied the impact of the Medicare Fee Schedule on physicians and beneficiaries, and the Medicare Volume Performance Standard system. She received a doctorate in public policy analysis from the RAND Graduate School.

SARAH HESPENHEIDE WILEY is an analyst. At the Commission, her work focuses on issues relating to secondary insurance for Medicare beneficiaries, the effects of secondary insurance on Medicare expenditures, and expenditure trends in Medicare. She earned her master's degree in health policy from the Johns Hopkins University School of Hygiene and Public Health.



# Commission Responsibilities Mandated by Congress

The Physician Payment Review Commission was established by the Congress in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272). It was charged with advising the Congress on methods to reform payment to physicians under the Medicare program. Recommendations were to be submitted to the Congress no later than March 1 of each year (amended to March 31 by OBRA87, P.L. 100-203).

The legislation called for the Commission to make recommendations to the Congress related to the development of a resource-based relative value scale for physicians' services. As part of this work, it was to consider options for reducing specialty and geographic differences in physician payments as well as assessing the implications of moving from Medicare's existing charge-based payment system to one based on resource costs. Its mandate also called for recommendations on ways to increase physician participation in the Medicare Participating Physician and Supplier Program, the feasibility of using physician diagnosis-related groups, and the appropriate use of assistants-at-surgery, and second opinions.

In the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), the Congress further directed the Commission to consider policies for moderating the rate of increase in expenditures for and utilization of physicians' services.

With the passage of Medicare physician payment reform in OBRA89 (P.L. 101-239), the Commission took on new responsibilities for advising the Congress on setting standards



for expenditure growth and updating fees; monitoring beneficiary access and financial liability; and conducting a series of studies on resource-based payments for practice expense, fee schedule payment areas, payment for nonphysician practitioners, physician payment under Medicaid, and payment for assistants-at-surgery.

In OBRA90 (P.L. 101-508), the Congress repealed requirements related to developing a resource-based payment system for Medicare and expanded the Commission's responsibilities to encompass issues affecting the broader health system. The Commission's current mandate includes:

- major issues in implementation of the Medicare Fee Schedule;
- further development of the Volume Performance Standard system, including development of state-based programs;
- payment incentives to increase access to primary care and other services in inner-city and rural areas, including federal policies regarding the level of Medicaid payments to physicians;
- the supply and specialty distribution of physicians and financing of graduate medical education;
- utilization review and quality of care, including the effectiveness of peer review organizations and other quality assurance programs;
- options to constrain the costs of health care to employers, including incentives under Medicare;
- medical malpractice reforms; and
- physician licensing and certification.

The Commission is also required to comment on the President's budget recommendations affecting physician payment under Medicare.

# Commission Publications

Since its creation in 1986, the Physician Payment Review Commission has submitted an annual report to the Congress each March. These reports address a range of policy issues reflected in its congressional mandate with a special focus on those issues of most immediate interest to the Congress. The Commission also publishes three congressionally mandated reports each spring on the Volume Performance Standard (VPS) system, access to care for Medicare beneficiaries under Medicare fee for service, and beneficiary financial liability under the Medicare Fee Schedule. Reports on the VPS system have been published annually since 1990. Reports on access to care and beneficiary financial liability have been published annually since 1991.

The Commission's other publications include additional reports mandated by the Congress; studies specifically requested by congressional committees and members; staff background papers, project reports and analyses; *Updates*; and results from Commission-sponsored research by outside groups.

All Commission publications, described below, can be obtained at no charge by sending electronic mail to [cwilson@pprc.gov](mailto:cwilson@pprc.gov), by writing the Commission at 2120 L Street NW, Suite 200, Washington, DC 20037, by calling the office at 202-653-7220, or by faxing requests to 202-653-7238. Some publications are also available from the Commission's Web site at [www.pprc.gov](http://www.pprc.gov). Please include the title and number or date of the publication with fax and electronic mail requests. Allow two to four weeks for delivery.

## REPORTS MANDATED BY THE CONGRESS

### *Annual Reports to Congress* (published annually since 1987)

These reports have been published each year since 1987. Among the topics covered in these reports are issues related to: development and implementation of the Medicare Fee Schedule, volume performance standards, Medicare managed care, health system reform, Medicaid managed care and beneficiary access, ensuring quality, graduate medical education, medical malpractice reform, risk adjustment, coverage decisions, practice guidelines, payments to nonphysician practitioners, and antitrust policy.

### *Fee Update and Medicare Volume Performance Standards* (published annually since 1990)

Each year, in this report required by the Omnibus Budget Reconciliation Act of 1989 (OBRA89), the Commission comments on the recommendations made by the Secretary of Health and Human Services on setting Medicare Volume Performance Standards and updating physician fees. It also makes its own recommendations for fee updates and for setting standards for Medicare physician expenditure growth. In addition, these reports describe trends in Medicare spending and changes in physician practice patterns affecting those trends. Past reports have included recommendations that would change the structure of the VPS policy to strengthen incentives to control volume growth and to correct for distortions in relative payments resulting from the current use of separate standards for different groups of services.

### *Monitoring Access of Medicare Beneficiaries* (published annually since 1991)

OBRA89 also directed the Commission to review and comment on the Secretary's report on monitoring changes in the utilization of, access to, and appropriateness of care provided under the Medicare Fee Schedule. In these reports, the Commission reviews the Secretary's plans, presents analyses of access, and outlines its future work plan to monitor and analyze changes in utilization and access.

### *Monitoring the Financial Liability of Medicare Beneficiaries* (published annually since 1991)

OBRA89 also required that, beginning in 1992, the Secretary of Health and Human Services monitor charges on unassigned claims, develop plans to address significant increases in beneficiary financial liability, and issue a report on these topics. The Commission report, which reviews and comments on the Secretary's findings, presents the Commission's analysis of charges, assignment and participation rates, and balance billing under Medicare's fee-for-service program.



*Comments on the President's Budget for Fiscal Years 1993 and 1994* (published June 1992 and 1993)

In these reports required by mandate, the Commission comments on provisions in the President's budget affecting Medicare, and other selected health programs.

*Physician Payment under Medicaid*, No. 91-4 (July 1991)

This report on Medicaid physician payment was mandated by the Congress in OBRA89. It provides an overview of the Medicaid program, analyzes available research on the relationship between Medicaid fee levels and access to care, and presents the findings from a 1990 Commission survey of state Medicaid programs concerning physician payment methodologies. The implications of raising Medicaid fees to Medicare levels are also examined.

*The Costs of Providing Screening Mammography*, No. 89-2 (June 1989)

Under the Medicare Catastrophic Coverage Act of 1988, the Commission was required to study the cost of providing screening mammography in a variety of settings and at different volume levels for women 65 and older. This report presents the results of the Commission's analyses of these costs and discusses the quality of screening mammography and patient compliance.

## **OTHER REPORTS REQUESTED BY THE CONGRESS**

*Joint Report to the Congress on Medicare Managed Care* (October 1995)

This report, issued jointly with the Prospective Payment Assessment Commission, is a primer on Medicare managed care. The report summarizes the work of both commissions on issues of beneficiary enrollment, plan participation, payment policy, ensuring quality and access, and assessing data needs and capabilities.

*Payment for Trauma and Critical Care Services*, No. 94-4 (July 1994)

This report was requested by the Senate Finance Committee and the House Committees on Ways and Means and on Energy and Commerce. It reviews the services provided by trauma and critical care specialists, assessing issues arising from current payment policies and policy changes made by the Health Care Financing Administration (HCFA). The report proposes recommendations both for monitoring the effects of HCFA's changes and for testing the application of a global payment to cover trauma services provided by physicians in hospitals designated to care for the most complex trauma patients.

*Expenditure Limits: Design and Implementation Issues*, No. 93-5 (July 1993)

This report was prepared in response to a request by the chair of the Subcommittee on Health of the House Committee on Ways and Means to consider issues involved in design and implementation of a global budgeting system as it relates to physicians' services. Issues considered include (1) allocation of a national budget among types of health services, (2) availability of data to support establishment and allocation of the national budget, and (3) establishment of maximum payment rates for enforcing budgetary limits. The Commission's experience with the design and implementation of Medicare physician payment reform provides a framework for the analysis.

*Study of Behavioral Offset for Radiology Services*, unnumbered (July 1993)

Prepared at the request of the chairs of three committees—Senate Finance, House Ways and Means, and House Energy and Commerce—this report examines radiologists' responses to the Medicare Fee Schedule. The report analyzes changes in payment for radiology services from 1989 to 1992 as well as changes in the volume of radiology services during that period. It concludes there was no reason to exempt radiology from volume offset reductions.

*Optional Payment Rates for Physicians: An Analysis of Section 402 of H.R.3626*, unnumbered (March 1992)

This technical report, prepared at the request of the chair of the House Committee on Ways and Means, analyzes a section of the chair's bill to establish payment rates based on the Medicare Fee Schedule that could be adopted by private payers. It considers adjustments that private payers would have to make, issues related to administration and implementation, and the potential impact on physicians, private payers, and patients.

## **OTHER COMMISSION REPORTS**

*Medicare Risk Plan Participation and Enrollment: A Chart Book* (December 1996)

This chartbook presents information about participation by plans and beneficiaries in Medicare's risk-contracting program. Plans are described with regard to number, geographic location, premiums, and additional benefits offered. Beneficiary enrollment patterns are presented in terms of levels over time and geographic distribution. Data are presented for the nation as a whole, for all 50 states, and for the 31 primary metropolitan statistical areas that have populations over 1.5 million.

*Payment for Professional Liability Insurance Expense under the Medicare Fee Schedule*, No. 92-7 (December 1992)

This research report presents results of the Commission's efforts to develop resource-based relative values for the malpractice component of the Medicare Fee Schedule. It describes an approach based on using professional liability insurance premiums to determine the relative risk of each service.

*Background Papers Presented at the Commission's Conference on Profiling*, No. 92-2 (April 1992)

In January 1992, the Commission held a conference to learn what is known about the appropriateness of present uses of physician profiling and to identify what would be required to realize the full potential of this technique. This report includes four papers commissioned for the conference. Issues covered include data needs, the potential and limitations of profiling, the impact of profiling on medical practice, and public access to profiling information.

*Practice Expense under the Medicare Fee Schedule: A Resource-Based Approach*, No. 92-1 (April 1992)

This research report describes the Commission's efforts to develop resource-based practice expense relative values. It focuses on three issues: the types of data required to develop resource-based relative values, the difficulty in collecting these data, and the decisions and issues that arise throughout the data collection and relative value calculation process. Analyses are presented that estimate payment levels across service families, specialties, and settings. A research agenda is outlined to advance further development of the resource-based approach.

*The Role of Specialty Societies and Physicians in the Commission's Evaluation of Relative Work Values*, No. 91-7 (November 1991)

This report describes the work of an interspecialty panel of health professionals convened by the Commission to comment on development of the scale of relative work for the Medicare Fee Schedule. It describes comments made by panelists and specialty societies concerning the clinical reasonableness of the relative work values and cross-specialty links released in Phase II of the study by William Hsiao and colleagues at Harvard.

*Comments on the Notice of Proposed Rulemaking for the Medicare Fee Schedule*, No. 91-6 (August 1991)

In June 1991, HCFA published a Notice of Proposed Rulemaking that outlined plans for implementation of the Medicare Fee Schedule beginning January 1, 1992. The Commission's report reviews a number of policy and technical issues concerning fee schedule implementation, focusing on calculation of the conversion factor and the scale of relative work. Among the specific issues addressed are structuring a budget-neutral transition to the new payment system, assumptions about changes in



service volume to offset changes in fees, establishing work relative values for visits and invasive procedures, developing resource-based values for practice and malpractice premium expenses, and defining fee schedule payment areas.

*Pre- and Postoperative Visits Associated with Surgical Global Services*, No. 91-2 (August 1991)

This report presents the results of a Commission project to develop pre- and postoperative visit patterns for major surgical procedures. Data were collected from surgical specialty societies, Medicare claims, and a national survey of practicing surgeons. Information presented in this report supports the Commission's recommendation that these visit patterns be used as the basis for payment for surgical global services under the Medicare Fee Schedule.

*Survey of Visits and Consultations*, No. 91-1 (April 1991)

This report presents results from a Commission-sponsored survey of physicians designed to provide information for revising visit and consultation codes and assigning relative values to them. The report describes the study design, methods, and results. Key issues considered include physician time involved in visits, the relationship between physician time and work, the role of physician-employed clinical personnel, and current use of visit codes.

*Medicare's Share in U.S. Physicians' Revenues*, No. 89-4 (December 1989)

This report presents the Commission's analysis of the share of physicians' revenues from Medicare-covered services. It refines previous estimates by adding in Medicare cost sharing and excluding specialties that see few Medicare patients.

*Variation in Medicare Global Service Policies: Relationship to Current Payment and Implications for a Fee Schedule*, No. 89-2 (November 1989)

This report presents the results of a Commission survey on the component services Medicare carriers include in their global fees for each of four common operations. It describes the survey methods and discusses policy implications.

## UPDATES

Updates are two page issue briefs intended to provide timely information on the Commission's work. This new series is published periodically.

*New Physician Work Values for the Medicare Fee Schedule* (January 1997)

*Expenditure Trends in Medicare* (Revised January 1997)

*Enrollment Growing in Medicare HMOs* (December 1996)

*How Do Plans Pay Network Physicians?* (November 1996)

*How Do Medicare Beneficiaries Fare in HMOs?* (October 1996)

*Access Is Good in Medicare Fee for Service* (October 1996)

*Will Competition Change the Work Force?* (October 1996)

*Evidence of Risk Selection in Medicare HMOs* (October 1996)

## SELECTED EXTERNAL RESEARCH REPORTS

These reports present complete results from Commission-sponsored projects. Most of these projects are referenced in other Commission reports.

*Access to Care in Medicare Managed Care: Results from a 1996 Survey of Enrollees and Disenrollees*, No. 7 (Washington, DC: Mathematica Policy Research, Inc., November 1996)

*Arrangements between Managed Care Plans and Physicians II: A Follow-Up on the Analysis of 1994 Survey Data and Site Visit Information*, No. 6 (Washington, DC: Mathematica Policy Research, Inc., June 1996)

*Identifying Hotspots of Poor Access to Care*, No. 5 (Washington, DC: National Committee to Preserve Social Security and Medicare, April 1996)

*Results of the 1994 National Survey of Physicians*, No. 4 (Rockville, MD: Project HOPE and the Gallup Organization, September 1995)

*Arrangements between Managed Care Plans and Physicians: Results from a 1994 Survey of Managed Care Plans*, No. 3 (Washington, DC: Mathematica Policy Research, Inc., February 1995)

*Models of Care for Inner City Populations*, No. 2 (Washington, DC: Center for Health Policy Research, George Washington University, November 1994)

*A Comparison of Alternative Approaches to Risk Measurement*, No. 1 (Minneapolis, MN: Park Nicollet Medical Foundation, November 1994)

*Survey of Physicians about the Medicare Program and Fee Schedule*, unnumbered (Chicago: National Opinion Research Center, May 1994)

*Physicians and the Medicare Fee Schedule: A Look at the Medicare Program and Other Payers in a Changing Practice Environment*, unnumbered (New York: Louis Harris and Associates, Inc., February 1993)

*Financial Incentives and Medical Practice: Evidence from Ontario on the Effect of Changes in Physician Fees on Medical Care Utilization*, No. 89-3 (Ontario, Canada: Centre for Health Economics and Policy Analysis, McMaster University, December 1989)

*Assignment and the Participating Physician Program: An Analysis of Beneficiary Awareness, Understanding, and Experience*, No. 89-1 (Washington, DC: Mathematica Policy Research, Inc., September 1989)



# Glossary

## ACRONYMS

AAHC	Association of Academic Health Centers
AAHP	American Association of Health Plans
AAMC	Association of American Medical Colleges
AAPCC	Adjusted Average Per Capita Cost
AAPHO	American Association of Physician-Hospital Organizations
AARP	American Association of Retired Persons
ACG	Ambulatory Care Group
ACR	Adjusted Community Rate
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AFDS	Alternative Financing and Delivery System
AHA	American Hospital Association
AHCPR	Agency for Health Care Policy and Research, HHS
AMA	American Medical Association
AMC	Academic Medical Center
CalPERS	California Public Employees' Retirement System
CBO	Congressional Budget Office
CISN	Community Integrated Service Network
CLEAR	Consolidated Licensure for Entities Assuming Risk
CMSA	Consolidated Metropolitan Statistical Area
CPEP	Clinical Practice Expert Panel
CPI	Consumer Price Index
CPI-U	Consumer Price Index for Urban Consumers
CPS	Current Population Survey
CPT	Current Procedural Terminology
CRS	Congressional Research Service
DCG	Diagnostic Cost Group
DRG	Diagnosis-Related Group
DSH	Disproportionate Share Hospital
EM	Evaluation and Management
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERISA	Employee Retirement Income Security Act of 1974

ESRD	End Stage Renal Disease
FAS	Financial Accounting Standard
FEHBP	Federal Employees Health Benefits Program
FY	Fiscal Year
GAF	Geographic Adjustment Factor
GAO	U.S. General Accounting Office
GDP	Gross Domestic Product
GHAA	Group Health Association of America
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Index
HCC	Hierarchical Coexisting Conditions
HCFA	Health Care Financing Administration, HHS
HCPP	Health Care Prepayment Plan
HEDIS	Health Plan Employer Data and Information Set
HER	Health Economics Research, Inc.
HHS	U.S. Department of Health and Human Services
HI	Hospital Insurance
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HUD	U.S. Department of Housing and Urban Development
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICF	Intermediate Care Facility
IDS	Integrated Delivery System
IME	Indirect Medical Education
IMG	International Medical Graduate
IPA	Independent Practice Association
IRS	Internal Revenue Service
ISN	Integrated Service Network
MCBS	Medicare Current Beneficiary Survey
MEI	Medicare Economic Index
MIG	Medicare Insured Group Demonstration
MPCC	Medicare Per Capita Cost
MPR	Mathematica Policy Research, Inc.
MSA	Medical Savings Account or Metropolitan Statistical Area
MSO	Management Service Organization
MTS	Medicare Transaction System
NAIC	National Association of Insurance Commissioners
NASHP	National Academy for State Health Policy
NCQA	National Committee for Quality Assurance
NHIS	National Health Interview Survey
NIH	National Institutes of Health, HHS

NMES	National Medical Expenditure Survey
OBRA	Omnibus Budget Reconciliation Act
ODS	Organized Delivery System
OIG	Office of the Inspector General, HHS
OPM	Office of Personnel Management
PACE	Program of All-Inclusive Care for the Elderly
PAR	Participating Physician and Supplier Program
PCCM	Primary Care Case Management
PHO	Physician-Hospital Organization
PHP	Prepaid Health Plan
PMSA	Primary Metropolitan Statistical Area
POS	Point of Service
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Peer Review Organization
ProPAC	Prospective Payment Assessment Commission
PSO	Provider-Sponsored Organization
QDWI	Qualified Disabled and Working Individual
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
RTI	Research Triangle Institute
RUC	RVS Update Committee
RVS	Relative Value Scale
RVU	Relative Value Unit
SAF	Standard Analytical Files (Medicare)
SLMB	Specified Low-Income Medicare Beneficiary
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
USPCC	U.S. Per Capita Cost
VA	U.S. Department of Veterans Affairs
VPS	Volume Performance Standard

## LEGISLATION (LISTED CHRONOLOGICALLY)

HMO Act	Health Maintenance Organization Act of 1973, P.L. 93-222, enacted December 29, 1973.
---------	---



<b>ERISA</b>	Employee Retirement Income Security Act of 1974, P.L. 93-406, enacted September 2, 1974.
<b>OBRA80</b>	Omnibus Budget Reconciliation Act of 1980, P.L. 96-499, enacted December 5, 1980.
<b>TEFRA</b>	Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, enacted September 3, 1982.
<b>DEFRA</b>	Deficit Reduction Act of 1984, P.L. 98-369, enacted July 18, 1984.
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, enacted April 7, 1986.
<b>OBRA86</b>	Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, enacted October 21, 1986.
<b>OBRA87</b>	Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, enacted December 21, 1987.
<b>MCCA</b>	Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, enacted July 1, 1988; repealed December 13, 1989.
<b>OBRA89</b>	Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, enacted December 19, 1989.
<b>OBRA90</b>	Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, enacted November 3, 1990.
<b>OBRA93</b>	Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, enacted August 10, 1993.
<b>Social Security Act Amendments of 1994</b>	Social Security Act Amendments of 1994, P.L. 103-432, enacted October 31, 1994.
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, enacted August 21, 1996.

## TERMS

**Academic Medical Center:** A group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professional schools.

**Access:** The ability to obtain needed health care services.

**Adjusted Average Per Capita Cost (AAPCC):** A county-level estimate of the average cost incurred by Medicare for each beneficiary in the fee-for-service system. Adjustments are made so that the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries. Medicare pays health plans 95 percent of the AAPCC, adjusted for the characteristics of the enrollees in each plan. See Medicare Risk Contract, U.S. Per Capita Cost.

**Adjusted Community Rate (ACR) Proposal:** A process by which a health plan with a Medicare risk contract estimates the cost of providing services to its Medicare enrollees based on costs and revenues from its commercial business. Health plans estimate their ACRs annually and adjust the subsequent year's supplemental benefits or premiums offered so that they do not receive a higher rate of return on Medicare enrollees than they do on their commercial business. See Adjusted Average Per Capita Cost, Medicare Risk Contract.

**Adverse Selection:** Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher than average costs are adversely selected. Plans with a subpopulation with lower than average costs are favorably selected.

**Aid to Families with Dependent Children (AFDC) Program:** A program established by the Social Security Act of 1935 and eliminated by welfare reform legislation in 1996. AFDC provided cash payments to needy children (and their caretakers) who lacked support because at least one parent was unavailable. Families had to meet income and resource criteria specified by the state to be eligible. AFDC has been replaced by a new block grant program, but AFDC standards are retained for use in Medicaid. See Temporary Assistance for Needy Families.

**Allowed Charge:** The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the allowed charge and the beneficiary pays the remaining 20 percent. The allowed charge for a nonparticipating physician is 95 percent of that for a participating physician. Nonparticipating physicians may bill beneficiaries for an additional amount above the allowed charge. See Balance Billing, Participating Physician and Supplier Program.

**Assignment (Medicare):** A process under which Medicare pays its share of the allowed charge directly to the physician or supplier. Medicare will do this only if the physician accepts Medicare's allowed charge as payment in full (guarantees not to balance bill). Medicare provides other incentives to physicians who accept assignment for all patients under the Participating Physician and Supplier Program. See Balance Billing, Nonparticipating Physicians, Participating Physician, Participating Physician and Supplier Program.

**Balance Billing:** In Medicare and private fee-for-service health insurance, the practice of billing patients in excess of the amount approved by the health plan. In Medicare, a balance bill cannot exceed 15 percent of the allowed charge for nonparticipating physicians. See Allowed Charge, Nonparticipating Physicians.

**Behavioral Offset:** See Volume Offset.

**Beneficiary:** Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs.

**Benefit Package:** Services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services. See Cost Sharing.

**Bonus Payment:** An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare's share of allowed charges. See Allowed Charge, Health Professional Shortage Area.

**Budget Neutrality:** For the Medicare program, adjustment of payment rates when policies change so that total spending under the new rules is expected to be the same as it would have been under the previous payment rules.

**Bundled Payment:** A single comprehensive payment for a group of related services.

**Buy-In:** Refers to the arrangements states make for paying Medicare premiums on behalf of those they are required or choose to cover. See Qualified Medicare Beneficiary, Specified Low-income Beneficiary.

**Capitation:** A health insurance payment mechanism which pays a fixed amount per person to cover services. Capitation may be used by purchasers to pay health plans or by plans to pay providers. See Medicare Risk Contract.

**Carrier:** A private contractor that administers claims processing and payment for Medicare Part B services. See Supplementary Medical Insurance.



**Carve-Out Coverage:** Carve-out refers to an arrangement where some benefits (e.g., mental health) are removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers. Also, carve-out may refer to a population subgroup for whom separate health care arrangements are made.

**Case Management:** Monitoring and coordinating the delivery of health services for individual patients to enhance care and manage costs; often used for patients with specific diagnoses or who require high-cost or extensive health care services.

**Coinsurance:** A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible by the insured. Under Medicare Part B, the insured pays coinsurance of 20 percent of allowed charges. See Allowed Charge, Copayment, Cost Sharing, Deductible.

**Community Rating:** A method for establishing health insurance premiums whereby an insurer's premium is the same for everyone in a premium class within a specific geographic area. See Premium, Experience Rating.

**Competitive Bidding:** A pricing method that elicits information on costs through a bidding process to establish payment rates that reflect the costs of an efficient health plan or health care provider.

**Competitive Medical Plan:** A health plan that is eligible for a Medicare risk contract (although it is not a federally qualified HMO) because it meets specified requirements for service provision, payment, and financial solvency. See Federally Qualified HMO.

**Conversion Factor:** The multiplicative factor used to translate relative value units into dollar amounts for physician payments under a fee schedule.

**Conversion Factor Update:** Annual percentage change to the conversion factor. For Medicare, the update is either established by the Congress or set by a formula to reflect whether actual expenditure growth from two years earlier fell below or above the target rate. See Conversion Factor, Performance Standard, Sustainable Growth Rate, Sustainable Growth Rate System, Volume Performance Standard System.

**Copayment:** A type of cost sharing under which the insured party is responsible for paying a fixed dollar amount per service. Sometimes used more generally as a synonym for cost sharing. See Coinsurance, Cost Sharing, Deductible.

**Cost Contract:** See Medicare Cost Contract.

**Cost Sharing:** A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, coinsurance, copayment, and balance bills are types of cost sharing. See Balance Billing, Coinsurance, Copayment, Deductible.

**Current Procedural Terminology (CPT):** The coding system for physicians' services developed by the CPT Editorial Panel of the American Medical Association; basis of the HCFA Common Procedure Coding System for physicians' services. See HCFA Common Procedures Coding System.

**Customary, Prevailing, and Reasonable:** The method of paying physicians under Medicare from 1965 until implementation of the Medicare Fee Schedule in January 1992. Payment for a service was limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the usual, customary, and reasonable system used by private insurers. See Medicare Fee Schedule; Usual, Customary, and Reasonable.

**Deductible:** A type of cost sharing where the insured party pays a specified amount of approved charges for covered medical services before the insurer will assume liability for all or part of the remaining covered services. See Coinsurance, Copayment, Cost Sharing.

**Defined Benefits Coverage:** An approach to providing health benefits whereby employers and other purchasers promise coverage for a specific package of health benefits.

**Defined Contribution Coverage:** A funding mechanism for health benefits whereby employers make a specific dollar contribution toward the cost of insurance coverage for employees.

**Diagnosis-Related Groups (DRGs):** A system of classifying patients on the basis of diagnoses for purposes of payment to hospitals. See Prospective Payment System.

**Disproportionate Share Hospital (DSH):** Those hospitals where persons covered by Medicaid or without any health insurance make up a large proportion of all patients served. Federal law authorizes special payments to these hospitals to help them meet the costs of serving those patients that are not covered by other revenue sources.

**Downstream Risk:** An arrangement where an entity (typically, a provider group) accepts risk from another entity (typically, a licensed organization like an HMO).

**Dually Eligible:** A Medicare beneficiary who also receives the full range of Medicaid benefits offered in his or her state.

**Encounter Data:** Description of the diagnoses made and services provided when a patient visits a health care provider under a managed-care plan. Encounter data provide much of the same information available on the bills submitted by fee-for-service providers.

**Evaluation and Management (EM) Service:** A nonprocedural service, such as a visit or consultation, provided by physicians to diagnose and treat diseases and counsel patients.

**Expenditure Limits:** A mechanism that adjusts payment levels downwards if spending levels or growth rates exceed predetermined spending caps.

**Expenditure Targets:** A mechanism that adjusts payment levels upwards or downwards depending on whether spending levels or growth rates meet prospectively determined targets or standards. Designed to hold spending to a predetermined budget trajectory.

**Experience Rating:** A system used by insurers to set premium levels based on the insured's past claims experience. For example, experience rating may be based on service utilization for health insurance or on liability experience for professional liability insurance. See Community Rating.

**Faculty Practice Plan:** An organization created to bill, collect and distribute income from professional fees of medical school faculty.

**Failsafe Budget Mechanism:** An overall limit on Medicare spending proposed in the Balanced Budget Act (H.R. 2491) passed by the Congress in November 1995.

**Federally Qualified HMO:** An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health service delivery information, utilization review and quality assurance, grievance procedures, financial status, and marketing information, as specified in Title XIII of the Public Health Service Act. See Health Maintenance Organization.

**Fee for Service:** A method of paying health care providers for individual medical services rendered, as opposed to paying them salaries or capitated payments. See Capitation.

**Fee Schedule:** A list of predetermined payment rates for medical services. See Medicare Fee Schedule.

**Fee Schedule Payment Area:** A geographic area within which payment for a given service under the Medicare Fee Schedule does not vary. See Geographic Adjustment Factor.

**Five-Year Review:** A review of the accuracy of Medicare's relative value scale that the Health Care Financing Administration is required to conduct every five years.



**Generalists:** Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically this includes family practitioners, general internists, and general pediatricians.

**Geographic Adjustment Factor (GAF):** The GAF for each service in a particular payment area is the average of the area's three geographic practice cost indexes weighted by the share of the service's total RVUs accounted for by the work, practice expense, and malpractice expense components of the Medicare Fee Schedule. See Geographic Practice Cost Index, Relative Value Units.

**Geographic Practice Cost Index (GPCI):** An index summarizing the prices of resources required to provide physicians' services in each payment area relative to national average prices. There is a GPCI for each component of the Medicare Fee Schedule: physician work, practice expense, and malpractice expense. The indexes are used to adjust relative value units to determine the correct payment in each fee schedule payment area. See Fee Schedule Payment Area, Medicare Fee Schedule.

**Graduate Medical Education (GME):** The period of medical training that follows graduation from medical school; commonly referred to as internship, residency, and fellowship training. See Undergraduate Medical Education.

**Gross Domestic Product (GDP):** The total current market value of all goods and services produced domestically during a given period; differs from the gross national product by excluding net income that residents earn abroad.

**Group-Model HMO:** An HMO that pays a medical group a negotiated, per capita rate, which the group distributes among its physicians, often under a salaried arrangement. See Health Maintenance Organization, Independent Practice Association, Network-Model HMO, Staff-Model HMO.

**Guaranteed Issue:** The requirement that each insurer and health plan accept everyone who applies for coverage and guarantee the renewal of that coverage as long as the applicant pays the premium.

**Guaranteed Renewable:** The requirement that each insurer and health plan continue to renew health policies purchased by individuals as long as the person continues to pay the premium for the policy.

**Hierarchical Coexisting Conditions Model (HCC):** A risk-adjustment model that groups beneficiaries based on their diagnoses.

**HCFA Common Procedure Coding System:** A Medicare coding system for describing services based on CPT, but supplemented with additional codes. See Current Procedural Terminology.

**Health Care Prepayment Plan (HCPP):** A health plan with a Medicare cost contract to provide only Medicare Part B benefits. Some administrative requirements for these plans are less stringent than those of risk contracts or other cost contracts. See Medicare Cost Contract, Medicare Risk Contract.

**Health Maintenance Organization (HMO):** A type of managed-care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers. See Group-Model HMO, Independent Practice Association, Managed Care, Network-Model HMO, Staff-Model HMO.

**Health Plan:** An organization that acts as insurer for an enrolled population. See Fee for Service, Managed Care.

**Health Professional Shortage Area (HPSA):** An urban or rural geographic area, a population group, or a public or nonprofit private medical facility that the Secretary of Health and Human Services determines is being served by too few health professionals. Physicians who provide services in HPSAs qualify for the Medicare bonus payment. See Bonus Payment.

**Hold Harmless:** A contractual provision that protects enrollees in the event of a health plan failure by prohibiting health care providers from collecting payment from enrollees for services rendered but not paid for by the plan.

**Hospital Insurance (HI):** The part of the Medicare program that covers the cost of hospital and related post-hospital services. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries are responsible for an initial deductible per spell of illness and copayments for some services. Also called Part A coverage or benefits.

**Independent Practice Association (IPA):** An HMO that contracts with individual physicians or small physician groups to provide services to HMO enrollees at a negotiated per capita or fee-for-service rate. Physicians maintain their own offices and can contract with other HMOs and see other fee-for-service patients. See Group-Model HMO, Health Maintenance Organization, Network-Model HMO, Staff-Model HMO.

**Integrated Delivery System (IDS):** An entity that usually includes a hospital, a large medical group, and an insurance vehicle such as an HMO or PPO. Typically, all provider revenues flow through the organization.

**Intensity of Service:** See Volume and Intensity of Services.

**Limiting Charge:** The maximum amount that a nonparticipating physician is permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993 the limiting charge has been set at 115 percent of the Medicare-allowed charge. See Allowed Charge, Balance Billing, Nonparticipating Physician.

**Locality (Medicare):** See Fee Schedule Payment Area.

**Malpractice Expense:** The cost of professional liability insurance incurred by physicians. A component of the Medicare relative value scale. See Relative Value Scale.

**Managed Care:** Any system of health service payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan. See Health Maintenance Organization, Independent Practice Association, Preferred Provider Organization.

**Management Services Organization (MSO):** An organization that provides a wide variety of administrative and practice management services to physicians. Some MSOs may limit their operations to selling physicians various administrative support services, such as billing, group purchasing, and office administration. Other MSOs purchase the assets of physician practices outright, install office managers and other personnel, and hire physicians through professional services contracts.

**Medicaid:** A program of federal matching grants to the states to provide health insurance for categories of the poor and medically indigent. States determine eligibility, payments, and benefits consistent with federal standards.

**Medical Underwriting:** See Underwriting.

**Medicare:** A health insurance program for people over age 65, those eligible for Social Security disability payments, and those who need kidney dialysis or transplants. See Hospital Insurance, Supplementary Medical Insurance.

**Medicare Choices Demonstration:** A demonstration project designed to offer flexibility in contracting requirements and payment methods for Medicare's managed-care program. Participating plans include PSOs and PPOs. Plans are required to submit encounter data to HCFA, and most will test new risk-adjustment methods.

**Medicare Cost Contract:** A contract between Medicare and a health plan under which the plan is paid on the basis of reasonable costs to provide some or all Medicare-covered services for enrollees. See Health Care Prepayment Plan, Medicare Risk Contract.



**Medicare Current Beneficiary Survey (MCBS):** A longitudinal survey administered by HCFA that provides information on specific aspects of beneficiary access, utilization of services, expenditures, health insurance coverage, satisfaction with care, health status and physical functioning, and demographic information.

**Medicare Economic Index (MEI):** An index that tracks changes over time in physician practice costs. From 1975 through 1991, increases in prevailing charge screens were limited to increases in the MEI. It is the starting point for updates under the VPS. See Volume Performance Standard.

**Medicare Fee Schedule:** The resource-based fee schedule Medicare uses to pay for physicians' services. See Resource-Based Relative Value Scale, Conversion Factor, Geographic Practice Cost Index.

**Medicare Risk Contract:** A contract between Medicare and a health plan under which the plan receives monthly capitated payments to provide Medicare-covered services for enrollees, and thereby assumes insurance risk for those enrollees. A plan is eligible for a risk contract if it is a federally qualified HMO or a competitive medical plan. See Adjusted Average Per Capita Cost, Adjusted Community Rate, Competitive Medical Plan, Medicare Cost Contract.

**Medicare SELECT:** A demonstration project that allows Medigap insurers to experiment with the provision of supplemental benefits through a network of providers. Coverage of supplemental benefits is often limited to those services furnished by participating network providers and emergency, out-of-area care.

**Medicare Transaction System (MTS):** MTS is a new electronic claims processing and information management system under development by the Health Care Financing Administration. When implemented it will act as a single, standardized repository of information related to fee-for-service Medicare, Medicare managed-care plans, and beneficiaries' secondary insurance.

**Medigap Insurance:** Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance, and balance bills, as well as payment for services not covered by Medicare. Medigap insurance must conform to one of ten federally standardized benefit packages.

**National Claims History System:** A HCFA data reporting system that combines both Part A and Part B claims in a common file. The National Claims History system became fully operational in 1991.

**Network-Model HMO:** An HMO that contracts with several different medical groups, often at a capitated rate. Groups may use different methods to pay their physicians. See Group-Model HMO, Health Maintenance Organization, Independent Practice Association, Staff-Model HMO.

**Nominal Value:** Measurement of an economic amount in terms of current prices. See Real Value.

**Nonparticipating Physician:** A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on all Medicare claims. See Assignment, Participating Physician, Participating Physician and Supplier Program.

**Outcome:** The consequence of a medical intervention or lack of an intervention on a patient.

**Out-of-Pocket Expenditures:** Health-related expenditures for which beneficiaries are financially liable. For Medicare beneficiaries, the total amount includes: cost sharing for Medicare-covered services (e.g., deductibles, copayments, and balance bills); cost of Medicare Part B and private health insurance premiums; and cost of non-covered services. See Cost Sharing, Balance Billing, Coinsurance, Copayment, Deductible.

**Paid Amount:** The portion of a submitted charge that is actually paid by both third-party payers and the insured, including copayments and balance bills. For Medicare this amount may be less than the allowed charge if the submitted charge is less, or it may be more because of balance billing. See Allowed Charge, Balance Billing, Payment Rate, Submitted Charge.

**Part A (Medicare):** See Hospital Insurance.

**Part B (Medicare):** See Supplementary Medical Insurance.

**Partial Capitation:** An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and payment based on actual use of services; the proportions specified for these components determine the insurance risk faced by the plan.

**Partial-Risk Contract:** A contract between a purchaser and a health plan in which only part of the financial risk is transferred from the purchaser to the plan.

**Participating Physician:** A physician who signs a participation agreement, agreeing to accept assignment on all Medicare claims for one year. See Assignment.

**Participating Physician and Supplier Program (PAR):** A program that provides financial and administrative incentives for physicians and suppliers to agree in advance to accept assignment on all Medicare claims for a one-year period. See Assignment.

**Payment Rate:** The total amount paid for each unit of service rendered by a health care provider, including both the amount covered by the insurer and the insured person's cost sharing; sometimes referred to as payment level. Also used to refer to capitation payments to health plans. See Allowed Charge.

**Peer Review Organization (PRO):** See Quality Improvement Organization.

**Performance Measure:** A specific measure of how well a health plan does in providing health services to its enrolled population. Can be used as a measure of quality. Examples include percentage of diabetics receiving annual referrals for eye care, screening mammography rate, and percentage of enrollees indicating satisfaction with care.

**Performance Standard:** The target rate of expenditure growth set by the Volume Performance Standard System. See Volume Performance Standard System.

**Physician-Hospital Organization (PHO):** An organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO may also undertake utilization review, credentialing, and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO, and typically continue in their traditional style of practice.

**Physician Work:** A measure of the physician's time, physical effort and skill, mental effort and judgment, and stress associated with providing a medical service. A component of the resource-based relative value scale. See Relative Value Scale.

**Point-of-Service (POS) Plan:** A managed-care plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network or nonnetwork providers at the time care is needed and usually are charged sizable copayments for selecting the latter. See Health Plan, Health Maintenance Organization, Preferred Provider Organization.

**Portability:** The requirement that insurers waive any preexisting condition exclusion for someone who was previously covered through other insurance as recently as 30 days to 90 days earlier. See Preexisting Condition Exclusion.

**Practice Expense:** The cost of nonphysician resources incurred by the physician to provide services. Examples are salaries and fringe benefits received by the physician's employees, and the expenses associated with the purchase and use of medical equipment and supplies in the physician's office. A component of the Medicare relative value scale. See Relative Value Scale.

**Practice Expense Relative Value:** A value that reflects the average amount of practice expenses incurred in performing a particular service. All values are expressed relative to the practice expenses for a reference service whose value equals one practice expense unit. See Relative Value Scale.

**Practice Guideline:** An explicit statement about the benefits, risks, and costs of particular courses of medical action based on the medical literature and expert judgement. Intended to help



practitioners, patients, and others make decisions about appropriate health care for specific clinical conditions.

**Preexisting Condition Exclusion:** A practice of some health insurers to deny coverage to individuals for a certain period, for example, six months, for health conditions that already exist when coverage is initiated. See Portability.

**Preferred Provider Organization (PPO):** A managed-care plan that contracts with networks or panels of providers to furnish services and be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use nonnetwork providers as well. See Managed Care.

**Premium:** An amount paid periodically to purchase health insurance benefits.

**Professional Liability Insurance (PLI):** The insurance physicians purchase to help protect themselves from the financial risks associated with medical liability claims.

**Profiling:** Expressing a pattern of practice as a rate—some measure of utilization (costs or services) or outcome (functional status, morbidity, or mortality) aggregated over time for a defined population of patients—to compare with other practice patterns. May be done for physician practices, health plans, or geographic areas.

**Program for All-Inclusive Care for the Elderly (PACE):** HCFA demonstration using managed-care programs to serve frail elderly persons who are, for the most part, dually eligible for Medicare and Medicaid and have been assessed as eligible for nursing home placement. The program provides adult day health care and case management to help the program participant maintain independent living in the community.

**Prospective Payment System (PPS):** The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. See Diagnosis-Related Groups.

**Provider-Sponsored Network (PSN):** In some usages, a PSN refers to a network of formally affiliated providers at the core of the PSO. See Provider-Sponsored Organization.

**Provider-Sponsored Organization (PSO):** Any organization created through the formal affiliation of health care providers that seeks to act as insurer for an enrolled population. PSOs can be physician-based, hospital-based, or a combination of both; typically, they are local health delivery systems.

**Quality Assurance:** A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies.

**Quality Improvement Organization (QIO):** An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries. Previously, these were called Peer Review Organizations.

**Qualified Medicare Beneficiary (QMB):** Medicare beneficiaries whose incomes are at or below 100 percent of the poverty level and whose resources do not exceed 200 percent of that allowed under the Supplemental Security Income program in each state. QMBs are entitled under federal law to have their Medicare premiums, coinsurance, and deductibles paid by the state in which they reside.

**Real Value:** Measurement of an economic amount corrected for change in price over time (inflation), thus expressing a value in terms of constant prices. See Nominal Value.

**Refinement:** The correction of relative values in Medicare's relative value scale that were initially set incorrectly or have become incorrect due to changes in medical practice.

**Reinsurance:** An insurance arrangement to protect insurers, health plans and providers against extraordinarily high costs. To accomplish this, an insurer pays a premium into a pool, and any claims paid by the insurer above a predefined dollar level are covered in whole or in part by the pool.

**Relative Value:** A value that reflects a comparison with a standard. See Relative Value Scale.

**Relative Value Scale (RVS):** An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. The RVS used in the Medicare Fee Schedule consists of three components: physician work, practice expense, and malpractice expense. See Malpractice Expense, Medicare Fee Schedule, Physician Work, Practice Expense, Resource-Based Relative Value Scale.

**Relative Value Unit (RVU):** The unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to establish payment amounts. See Conversion Factor, Relative Value, Relative Value Scale.

**Resource-Based Relative Value Scale (RBRVS):** A relative value scale based on the resources involved in providing a service. See Relative Value Scale.

**Revenue Share:** The proportion of total revenue devoted to a particular type of expense. For example, the practice expense revenue share is that proportion of revenue used to pay for practice expense.

**Risk Adjustment:** The process used to adjust payments to plans to compensate for differences in health status of enrollees across plans.

**Risk Adjuster:** A measure used to adjust payments in order to compensate for spending that is expected to be lower or higher than average, based on the health status or demographic characteristics of enrollees.

**Risk Contract:** See Medicare Risk Contract.

**Risk Selection:** Any situation in which health plans differ in the health risk associated with their enrollees because of enrollment choices made by the plans or enrollees. As a result, one health plan's expected costs differ from another's due to underlying differences in their enrolled populations. See Adverse Selection.

**Risk Sharing:** A method, such as partial capitation, that places a health plan at less than full risk by covering the cost of selected services, providing additional payment amounts for high cost patients or to offset plan losses.

**Scored Savings:** Amount of savings expected to result from enacting new legislation. Estimated by the Congressional Budget Office by calculating the difference in spending projected under current law and under the proposed legislation.

**Secondary Insurance:** Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans, and Medicaid.

**Self-Insured Health Plan:** Employer-provided health insurance in which the employer, rather than an insurer, is at risk for its employees' medical expenses.

**Site-of-Service Differential:** The difference in the amount paid to the physician when the same service is performed in different practice settings, for example, a colonoscopy in a physician's office or a hospital clinic.

**Social Health Maintenance Organization (SHMO):** HCFA demonstration project which expands the Medicare benefit package in order to reduce or slow functional impairment of frail beneficiaries. Additional covered services include nursing home, homemaker, transportation, drugs, and case management services.

**Specified Low-Income Medicare Beneficiary (SLMB):** Medicare beneficiaries who have incomes below 120 percent of the federal poverty level and whose resources do not exceed 200 percent of that allowed under the SSI program in each state. States are required, under federal law, to pay the Medicare Part B premiums for resident SLMBs.

**Staff-Model HMO:** An HMO in which physicians practice solely as employees of the HMO and usually are paid a salary. See Group-Model HMO, Health Maintenance Organization.



- Standard Benefit Package:** A defined set of health insurance benefits that all insurers are required to offer. See Benefit Package.
- Submitted Charge:** The charge submitted by a provider to the patient or a payer. See Paid Amounts.
- Supplemental Security Income (SSI):** A federal income support program for low-income disabled, aged, and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions and differs by state.
- Supplementary Medical Insurance (SMI):** The part of the Medicare program that covers the costs of physicians' services, outpatient laboratory and X-ray tests, durable medical equipment, outpatient hospital care, and certain other services. This voluntary program requires payment of a monthly premium, which covers 25 percent of program costs with the rest covered by general revenues. Beneficiaries are responsible for a deductible and coinsurance payments for most covered services. Also called Part B coverage or benefits.
- Supplier:** A provider of health care services, other than a practitioner, that is permitted to bill under Medicare Part B. Suppliers include independent laboratories, durable medical equipment providers, ambulance services, orthotists, prosthetists, and portable X-ray providers.
- Sustainable Growth Rate:** The target rate of expenditure growth set by the Sustainable Growth Rate system. Similar to the performance standard under the Volume Performance Standard system, except that the target depends on growth of gross domestic product instead of historical trends. See Sustainable Growth Rate System, Volume Performance Standard System, Performance Standard.
- Sustainable Growth Rate System:** A revision to the Volume Performance Standard system, proposed by the Congress and the Administration. This system would provide an alternative mechanism for adjusting fee updates for the Medicare Fee Schedule. The mechanism would use a single conversion factor, base target rates of growth on growth of gross domestic product, and change the method for calculating the conversion factor update to eliminate the two year delay. See Volume Performance Standard System, Conversion Factor Update.
- Temporary Assistance for Needy Families:** New block grant program created under federal welfare reform legislation (P.L. 104-193). Replaces Aid to Families with Dependent Children (AFDC). Medicaid eligibility is not linked to TANF as it had been to AFDC. See Aid to Families with Dependent Children.
- Undergraduate Medical Education:** The medical training provided to students in medical school. See Graduate Medical Education.



**Underwriting:** The process by which an insurer determines whether and on what basis it will accept an application for insurance. Some insurers use medical underwriting to exclude individuals, groups, or coverage for certain health conditions that are expected to incur high costs.

**Underwriting Cycle:** The cyclical pattern of insurer profitability and premium prices in group health insurance. The underwriting cycle consists of three phases. Phase I is characterized by rapid price increases and rising revenue for insurance companies. Phase II is marked by relatively stable premium prices and an increase in insurers' capital reserves. Phase III consists of increasing premium price competition and the depletion of insurers' capital reserves.

**Unified Insurance:** Health insurance coverage that is provided through a single insurance policy.

**U.S. Per Capita Cost (USPCC):** The national average cost per Medicare beneficiary, calculated annually by HCFA's Office of the Actuary. See Adjusted Average Per Capita Cost, Medicare Risk Contract.

**Usual, Customary, and Reasonable:** A method used by private insurers for paying physicians based on charges commonly used by physicians in a local community. Sometimes called customary, prevailing, and reasonable charges. See Customary, Prevailing, and Reasonable.

**Utilization Review:** The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary; may be performed on a concurrent or retrospective basis.

**Volume and Intensity of Services:** The quantity of health care services per enrollee, taking into account both the number and the complexity, or mix of the services provided.

**Volume Offset:** The change in the number and mix of services that is projected to occur in response to a change in fees. A 50 percent behavioral offset means that half the savings from fee reductions will be offset by increased volume and intensity of services. Used to estimate budget effects for Medicare payment changes. Also referred to as behavioral offset.

**Volume Performance Standard (VPS) System:** Mechanism to adjust fee updates for the Medicare Fee Schedule based on how annual increases in actual expenditures compare with previously determined performance standard rates of increase.

**Work Relative Value:** A value that reflects the average amount of physician work incurred in performing a particular service, relative to that of other services. See Relative Value Scale.





CMS LIBRARY



3 8095 00009642 6

Physician Payment Review Commission

2120 L Street, NW, Suite 200

Washington, DC 20037

(202) 653-7220 fax (202) 653-7238

[www.pprc.gov](http://www.pprc.gov)